

**PUBLIC RECORD****Dates:** 30/09/2025 - 28/10/2025**Doctor:** Dr Antonios ZAMAR**GMC reference number:** 3637384**Primary medical qualification:** MB BCh 1989 Cairo

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Not impaired

**Summary of outcome:**

No warning

**Tribunal:**

Legally Qualified Chair	Mr Malcolm Dodds
Lay Tribunal Member:	Dr Helen McCormack
Registrant Tribunal Member:	Mr George Ritchie
Tribunal Clerk:	Ms Maria Khan 30/09/25 – 23/10/25 Ms Fiona Johnston 24/10/25 – 28/10/25

**Attendance and Representation:**

Doctor:	Present, represented
Doctor's Representative:	Mr Stephen Brassington , Counsel, instructed by Clyde&Co
GMC Representative:	Ms Jade Bucklow, Counsel

## Attendance of Press / Public

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

## Overarching Objective

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

## Determination on Facts and Impairment - 28/10/2025

### Background

1. Dr Zamar is a Consultant Psychiatrist. He obtained his primary medical qualification in 1982 in Cairo, Egypt, and registered with the General Medical Council ('GMC') in 1992. Dr Zamar has been on the Specialist Register since April 1999 and registered with a licence to practise since 2009.
2. Dr Zamar is the Medical Director and Founder of The London Psychiatry Centre, a private clinic in Harley Street, London which opened in 2011. Dr Zamar does not have an NHS practice. It was from The London Psychiatry Clinic that Dr Zamar was offering 'The Zamar Protocol'.
3. The Zamar Protocol is a treatment protocol that Dr Zamar has developed for the treatment of Bipolar Spectrum Disorders, including Subthreshold Bipolar Disorder ('SBD') treatment resistant depression and / or major depressive disorder. The protocol is a combination of two treatment modalities: high dose Levothyroxine and repetitive Transcranial Magnetic Stimulation (rTMS). Levothyroxine is a thyroid hormone used in the treatment of hypothyroidism. rTMS appears in the National Institute for Health and Care Excellence ('NICE') guidance as a treatment for depression.
4. Dr Zamar asserts expertise in the treatment of bipolar spectrum disorders using this combination of high dose Levothyroxine and rTMS. He is the author of several papers on the subject.

5. The allegations that have led to Dr Zamar's hearing relate to Patients C and D. They can be summarised as follows. In relation to Patient C, it is alleged that Dr Zamar misdiagnosed her and he failed to consider other first line treatments with a stronger evidential base. It is further alleged that at all material times when Dr Zamar treated Patient C between 19 January and 19 March 2021, she was vulnerable due to her mental health and personal circumstances. In relation to Patient D, it is alleged that Dr Zamar failed to adequately diagnose her condition in that he did not consider the complexity or context of her case. It is also alleged that, between February and May 2022, Dr Zamar prescribed medication, acting outside his competency, disregarding the opinion of a child and adolescent psychiatrist, and which was inappropriate treatment. Further, it is alleged that Patient D was vulnerable at all material times due to her mental health and by virtue of the fact that she was a minor.

#### Patient C

6. Dr Zamar first consulted with Patient C on 19 January 2021. He diagnosed Patient C with major depression with subthreshold / unspecified bipolar disorder, rapid cycling and initiated treatment with The Zamar Protocol. He also identified symptoms of Post Traumatic stress disorder (PTSD), to be evaluated at a later stage.

7. Dr Zamar did not identify any previous psychiatric history or psychiatric diagnosis for Patient C, other than a period of psychotherapy with Dr F, a Psychologist. In a letter to Patient C's insurers on 20 January 2021, Dr Zamar indicated the psychotherapy took place around six months prior to his involvement, following marital discord and for her mood.

8. Patient C had her last consultation on 19 March 2021. During this consultation, Patient C reported exhaustion, and it was queried whether she had COVID-19. This was Dr Zamar's last involvement with Patient C, and he was referred to the GMC the following day, 20 March 2021, and subsequently on 8 June 2021.

#### Patient D

9. Prior to Dr Zamar's involvement, Patient D was being treated by a Consultant Child and Adolescent Psychiatrist at the London Psychiatry Centre, Dr E. Patient D first presented to Dr E on 11 June 2019 as a self-referral in respect of anxiety, and she underwent a Child and Adolescent Mental Health Service ('CAMHS') initial assessment. Patient D was assessed as having anxiety and a low mood that was not at that time severe enough to be classified as

depression. The plan was for cognitive behavioural therapy ('CBT'), mindfulness and support at school.

10. Patient D presented to Dr E again on 12 October 2021, as a self-referral by the family following a deterioration in Patient D's anxiety and mood. Dr E carried out a further CAMHS assessment. The report indicated that since Patient D had last been seen, she had undertaken 12 sessions of CBT which had partially relieved her anxiety, and she had been functioning well at school. Patient D had a troubled relationship with her father, which she described as abusive, and this had declined further during the COVID-19 lockdown period. Patient D had the involvement of a clinical psychologist and a private GP. On assessment on 12 October 2021, Dr E elicited no evidence of major mental illness and felt that Patient D had had a relapse of her anxiety and had developed significant depression. Patient D was prescribed Fluoxetine 10mg, to gradually increase to 20mg. On 4 January 2022, Dr E prescribed Fluoxetine at 40mg per day.

11. Patient D presented to A&E on 12 January 2022, following an overdose of 48 paracetamol tablets. She was seen by a CAMHS crisis team and referred to Bromley CAMHS.

12. Patient D's family first initiated contact with Dr Zamar about Patient D indirectly through a mutual close friend of both parties. Patient D's mother emailed Dr Zamar on 13 February 2022. In the email she stated she was worried that the treatment Patient D was having for her depression and severe anxiety (Fluoxetine) was not working. Within the email Patient D's mother stated they desperately needed Dr Zamar's help and they wanted Patient D to "*do the rTMS treatment*", which they were ready to start as soon as he advised.

13. The same day Dr Zamar emailed Dr E outlining his opinion on why patients such as Patient D should be referred for rTMS and that his clinic was insured to treat children with rTMS. At this stage Patient D had not yet consulted with Dr Zamar. Within the email there was no mention of treating Patient D with Levothyroxine or the Zamar Protocol. Dr Zamar asked Dr E if she had any objection to Dr Zamar seeing Patient D and giving an opinion.

14. Later that day Dr E replied to Dr Zamar by email, indicating that she had no problem re rTMS and that it may be very helpful. In that email Dr E warned Dr Zamar about the complexity of Patient D's case and reminded Dr Zamar that their duty was to the young person, irrespective of what her mother wanted. Dr E set out several concerns which can be summarised as follows:

- Patient D's mother had a habit of splitting between professionals;

- Patient D's mother agreed to things in session but did not follow through;
- Patient D's mother seemed to want Patient D *"fixed"* and was prepared to pay *"££"* without seeing their role as parents was crucial in the process;
- Patient D's mother viewed each new professional as a *"saviour"* after she became disillusioned with the last;
- There were safeguarding concerns regarding ongoing abuse XXX and concern that the mother minimised this;
- There was concern that lots of people being involved may be overwhelming, and that Patient D's mother may undermine professionals in front of Patient D so she was less likely to engage.

15. Dr E also informed Dr Zamar that she had been doing her best to liaise with Patient D's network, which included a 1-1 counsellor, her school, GP, hospital, and CAMHS, to ensure that she was stable. Dr E wanted to first speak to the CAMHS Team before handing over psychiatric responsibility for Patient D to Dr Zamar.

16. On 14 February 2022 Dr E phoned Bromley CAMHS and spoke with Ms G, Head of Adolescent Team, Bromley CAMHS. On 15 February 2022 she informed Dr Zamar that Ms G had indicated that:

- CAMHS would be taking on Patient D's care. However, due to staff shortages they would only offer risk monitoring initially;
- In due course CAMHS would allocate Patient D a case manager and psychiatrist;
- She had been informed of the likely transfer of psychiatric care from Dr E to Dr Zamar;
- She had agreed that intensive monitoring offered during rTMS would be useful; and
- She was going to organise a network meeting and would contact the London Psychiatry Centre about this.

Patient D's care was then handed over from Dr E to Dr Zamar.

17. On 15 February 2022 Dr Zamar consulted with Patient D for the first time. He had access to all the case notes and the email from Dr E. Dr Zamar used the HCL-32 hypomania checklist, the Beck Anxiety Inventory and the Beck Depression Inventory with Patient D. Following that, Dr Zamar interviewed Patient D in the presence of her family. He took a history from her, confirmed by her family, that she was severely depressed and also clearly showed a high level of irritability, racing thoughts, and out of character impulsivity worsening with Fluoxetine. In the course of that appointment, Dr Zamar diagnosed Patient D with SBD and that her condition was *"worsened, if not triggered by, antidepressant"*. Dr Zamar advised

Patient D to withdraw from Fluoxetine. Dr Zamar wrote to Dr E informing her of his diagnosis and that he had explained treatment with rTMS and Levothyroxine to Patient D and her mother. Within the letter Dr Zamar told Dr E that his plan was to deploy an rTMS protocol, treating both PTSD and the mood disorders simultaneously.

18. Between 15 February 2022 and 20 May 2022, Dr Zamar consulted with Patient D on approximately 20 occasions. Schedule 1, below, sets out the various medications prescribed by Dr Zamar to Patient D during that period.

19. Dr Zamar recommended rTMS treatment on 15 February 2022 and prescribed Levothyroxine on 25 February 2022, in accordance with the Zamar Protocol.

20. On 25 February 2022, he reviewed Patient D who *“still reported the occurrence of racing thoughts together and depressed mood and agitation”*. She described constantly feeling on edge. He reported that Patient D had T-wave abnormalities on ECG and referred her to Dr H (a cardiologist). Dr Zamar prescribed Patient D Alprazolam 0.25mg three times a day for a month, Quetiapine 50mg at night for a month and Levothyroxine 200mcg daily for seven days.

21. On 2 March 2022 Dr Zamar continued Patient D on Levothyroxine 200mcg daily. On 4 March 2022 he set out in the clinic letter the thyroid tests and ECG findings. Dr Zamar increased Levothyroxine to 250mcg, reduced Fluoxetine to 10mg daily and prescribed Alprazolam at 0.25mg and continued the rTMS dose at 20Hz.

22. On 10 March 2022 Dr Zamar set out in his clinic letter the genetics test results *“as anticipated”*, and possible withdrawal symptoms from the Fluoxetine reduction. Dr Zamar increased the Levothyroxine dose to 300mcg daily, increased Alprazolam to 0.5 mg three times daily and 1mg three times daily *“if needed”*.

23. On 15 March 2022 he diagnosed withdrawal symptoms from Fluoxetine and increased the Fluoxetine to 16mg daily with view for a more gradual and slow reduction. He increased Levothyroxine to 350mcg, advised Patient D to *“be liberal with Alprazolam”* (Schedule 1 says 1mg) and increased Quetiapine to 50mg twice daily then on 21 March 2022 to 100mg twice daily.

24. On 23 March 2022 Dr Zamar reported that the withdrawal symptoms from Fluoxetine had *“eased to some extent”*. He increased Quetiapine to 100mg twice daily, increased Levothyroxine to 400mcg daily, continued rTMS, and increased Alprazolam to 2mg three

times daily. On 25 March 2022 Dr Zamar advised no change to Levothyroxine at 400mcg daily and Alprazolam at 2mg but increased Fluoxetine to 20mg daily and increased Quetiapine to 100mg morning and 200mg at night.

25. On 28 March 2022 Dr Zamar reported keeping Quetiapine at 100mg morning and 200mg at night, Alprazolam (2mg) and Fluoxetine (20mg) i.e. all at the same dose but increased Levothyroxine to 450mcg daily. On 1 April 2022 he continued to prescribe Quetiapine at 100mg in the morning and 200mg at night, and switched to Clonazepam at 2mg at night (*“same dose equivalent”*) (there being a shortage of Alprazolam).

26. On 4 April 2022 according to Schedule 1, Dr Zamar advised stopping the Quetiapine in the morning, increasing Levothyroxine to 500mcg daily (with a referral to a consultant endocrinologist for advice), no change to Alprazolam (2mg) and Fluoxetine (20mg). On 7 April 2022 Dr Zamar prescribed Levothyroxine 500mcg daily, Alprazolam 2mg three times daily and Quetiapine 200mg at night.

27. On 11 April 2022 Dr Zamar increased Levothyroxine to 550mcg daily, reduced Fluoxetine to 12mg daily, same dose Alprazolam (2mg) and Quetiapine (200mg). On 14 April 2022 Dr H prescribed Ivabradine. Dr Zamar advised reducing Fluoxetine gradually to 8mg daily in four weeks, then to 4mg and then stopping, with a plan to increase Levothyroxine to 600mcg daily from the following week.

28. On 25 April 2022 Dr Zamar reduced Fluoxetine to 8mg, increased Levothyroxine to 600mg daily, kept the same dose of Quetiapine at 200mg daily and Clonazepam 2mg daily. On 28 April 2022 Dr Zamar reduced Fluoxetine to 4mg daily, kept Levothyroxine at 600mcg and referred Patient D to a Dr I for Pabrinex 2 vials twice daily for four days or so as treatment for Vitamin B1 deficiency.

29. On 29 April 2022 Patient D attended A&E after self-harming. On 3 May 2022 Dr Zamar reported that Patient D had cut her wrists, had gone to A&E and had been discharged home. Dr Zamar made a referral to Dr S, Consultant Psychiatrist, Claimont home nursing, for Patient D to receive care at home. Dr Zamar prescribed Quetiapine at 200mg. On 10 May 2022 he stopped Fluoxetine and continued with rTMS and Levothyroxine at 600mcg.

30. On 12 May 2022 Dr Zamar stopped Levothyroxine for five days and restarted on day six at 400mcg daily, continuing Pabrinex injections with Dr I. Schedule 1 states that Dr Zamar prescribed Levothyroxine at 600mcg. On 17 May 2022 Dr Zamar restarted Levothyroxine at

400mcg from the following day. He reported that Patient D *“felt much better after eating and Pabrinex injections”*.

31. On 20 May 2022 Dr Zamar continued with Levothyroxine 400mcg. On 21 May 2022 Patient D self-harmed and was taken to A&E. On 23 May 2022 Dr Zamar had a telephone call with Patient D’s parent, who had concerns because she *“wanted to kill her parents”*. They took her to the local A&E.

32. On 25 May 2022 Dr Zamar wrote a letter to the Duty Worker Oxleas CAMHS, copied to Patient D’s GP and other professionals and Patient D’s parents, explaining his diagnosis, medication, side effects, treatment plan and protocol, safety netting. Following her hospital admission, Patient D never returned to Dr Zamar’s care.

33. Dr Zamar was referred to the GMC in respect of Patient D on 31 May 2022. At the relevant time, Patient D was 16 years old (XXX).

### **The Outcome of Applications Made during the Facts Stage**

34. On 3 October 2025 (Day 3 of the hearing) the Tribunal rejected an application made by Ms Jade Bucklow, Counsel for the GMC, made pursuant to Rules 16 and 34 of the General Medical Council (Fitness to Practise Rules) 2004 as amended (‘the Rules’), for a bundle of evidence that supported its case to be admitted. The Tribunal’s determination on the application is included at Annex A.

35. On the same date, the Tribunal granted Ms Bucklow’s application made pursuant to Rule 17(6) of the Rules, to withdraw paragraph 1(a) of the Allegation and to amend paragraph 5(d). The Tribunal’s written determination on the application is included at Annex B.

36. On 15 October 2025 (Day 10 of the hearing), Mr Stephen Brassington, Counsel on behalf of Dr Zamar, made an application pursuant to Rule 17(2)(g) of the Rules, that there was ‘no case to answer’ in respect of paragraphs 1, 2, 4(a)-4(b) and 5(a)-5(e) of the Allegation. The Tribunal granted the application in respect of paragraphs 1, 2 and 5(e), rejecting the application in respect of the remaining paragraphs. The Tribunal’s written determination on the application is included at Annex C.

### **The Allegation and the Doctor’s Response**

37. The Allegation made against Dr Zamar is as follows:

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

**Patient C**

1. ~~On 19 January 2021 you:~~
  - a. ~~failed to carry out a capacity assessment with Patient C;~~ **Withdrawn under Rule 17(6)**
  - b. ~~misdiagnosed Patient C with ‘major depression with subthreshold bipolar feature or unspecified bipolar disorder’.~~ **Deleted under Rule 17(2)(g)**
2. ~~Between 19 January and 19 March 2021 you failed to consider other first line treatments with a stronger evidence base.~~ **Deleted under Rule 17(2)(g)**
3. At all material times Patient C was vulnerable due to their mental health and personal circumstances at the time. **Admitted and found proved**

**Patient D**

4. On 15 February 2022, you failed to adequately diagnose Patient D’s condition, in that you did not consider the:
  - a. complexity of Patient D’s case; **To be determined**
  - b. context of Patient D’s case. **To be determined**
5. Between 25 February and 17 May 2022, you prescribed Patient D the medication as set out in Schedule 1, and you:
  - a. acted outside of your competency; **To be determined**
  - b. disregarded the opinion of a Child and Adolescent Psychiatrist; **To be determined**
  - c. prescribed high dose Levothyroxine, which was contraindicated for Patient D, a child, who had normal thyroid function; **To be determined**
  - d. ~~made fast changes to Patients D’s Alprazolam/Quetiapine dosages;~~  
simultaneously prescribed and/or made fast changes to Patients D’s Alprazolam and Quetiapine dosages; **Amended under Rule 17(6)**  
**To be determined**
  - e. ~~increased Patient D’s Repetitive Transcranial Magnetic Stimulation (‘rTMS’) dose from 1Hz to 20Hz, which was inappropriate in that the:~~

- i. ~~rTMS dose should not have exceeded 10Hz;~~  
**Deleted under Rule 17(2)(g)**
- ii. ~~dosage was suddenly increased.~~  
**Deleted under Rule 17(2)(g)**

6. At all material times Patient D was vulnerable due to their mental health and by virtue of the fact that they were a minor. **To be determined**

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

### The Admitted Facts

38. At the outset of these proceedings, through his counsel, Mr Brassington, Dr Zamar made admission to paragraph 3 and part of paragraph 6 of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced that paragraph 3 of the Allegation was admitted and found proved.

### Witness Evidence

39. Dr Zamar provided his own witness statements, dated 3 September 2025 and 6 October 2025, and also gave oral evidence at the hearing.

### Expert Witness Evidence

40. The Tribunal received evidence on behalf of the GMC from Dr J, Consultant in General Adult Psychiatry, and Dr K, Consultant Child and Adolescent Psychiatrist. It received written evidence on behalf of Dr Zamar from Dr L Consultant Psychiatrist, and Dr M Consultant in Mental Health and Addiction Psychiatry, as set out below.

41. The two GMC expert witnesses gave oral evidence at the hearing. The Tribunal also had regard to the following reports:

- Expert report of Dr N in respect of Patient C, dated 10 January 2023;
- Supplemental expert report of Dr J, dated 12 May 2025;
- Expert report of Dr K in respect of Patient D, dated 2 December 2022;
- Supplemental expert report of Dr K, dated 6 May 2025;
- Expert report of Dr L, in respect of Patient C, completed in September 2024;

- Supplemental expert report of Dr L, dated 27 August 2025;
- Expert report of Dr M dated 28 August 2025;
- Joint expert statement of Dr J and Dr L, dated 22 September 2025.

42. The expert reports assisted the Tribunal in its understanding of the standard of care expected of a reasonably competent Consultant Psychiatrist, and how Dr Zamar's actions and / or omissions during his care of Patient C and Patient D could have fallen below, or seriously below, that standard.

### Documentary Evidence

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

- Patient records of Patient C and Patient D;
- Chronology of Patient D's treatment and care;
- Medical literature from Dr Zamar relating to (amongst other things) the following;
  - Subthreshold Bipolar Disorder;
  - Bipolarity Index;
  - The Diagnostic Hierarchy;
  - High Dose Levothyroxine and rTMS;
  - Bipolar Disorder in young adults;
- NICE Bipolar Disorder Guidelines;
- Report for the Interim Orders Tribunal ('IOT') from Dr O, Dr Zamar's assessor, dated 4 July 2025, as well as five case-based discussion reports documented from February – June 2025.

### Submissions

44. Paragraph 4 of the Allegation states that on 15 February 2022 Dr Zamar failed to adequately diagnose Patient D's condition, in that he did not consider (a) the complexity of Patient D's case and (b) the context of Patient D's case.

45. Ms Bucklow submitted that the complexity of Patient D's case was not disputed. Ms Bucklow submitted that there was a degree of overlap between what made Patient D's case

complex and the relevant context, which included the family dynamics, particularly in relation to Patient D's parents (as set out by Dr E).

46. Ms Bucklow submitted that paragraph 4 was demonstrated by (1) the correspondence Dr Zamar exchanged with Dr E, (2) the actions he took when taking over Patient D's care, and (3) the speed with which he diagnosed Patient D and initiated various treatments on 15 February 2022. Ms Bucklow submitted that Dr Zamar made the wrong diagnosis.

47. The Tribunal noted that making an incorrect diagnosis was not an allegation for the Tribunal to consider. Ms Bucklow submitted that Dr Zamar proceeded to consult with Patient D, make a diagnosis and instigate a treatment plan before any input from the NHS was fed back to him from Dr E. Ms Bucklow submitted that Dr Zamar's approach was indicative of a complete lack of regard to the complexity of Patient D's case and the necessary multi-agency approach in child and adolescent mental health provision.

48. Ms Bucklow submitted that within the space of one appointment Dr Zamar diagnosed Patient D with SBD and recommended treating her using the Zamar Protocol (high dose Levothyroxine and rTMS). Within days rTMS was commenced, and Levothyroxine, Quetiapine and Alprazolam were commenced on 25 February 2022. Ms Bucklow submitted that Dr K's evidence was that Dr Zamar rushed to make a diagnosis of bipolar disorder without appreciating the context and complexity of Patient D's case.

49. Dr K gave written and oral evidence that mainstream practice among children and adolescents psychiatrists in the UK is very careful about the use of the label of Bipolar Disorder let alone SBD (Appendix J of his witness statement). His evidence was that unlike adults, most of the children who have similar presentation as Patient D do not necessarily fit into a neat diagnostic rubric due to a number of predisposing and maintaining factors. He gave examples such as attachment issues, emotional instability and lack of skills tolerating or handling distress, history of abuse or trauma, parental conflict, parental unrealistic expectations, pressures and stress related to exams/peer/identity, etc. His evidence was that in his experience across different facilities in the UK, most child and adolescent psychiatrists would adopt a biopsychosocial approach and would consider that less was more when considering medication.

50. In Dr K' opinion Dr Zamar strongly believed in a medical model and used many types of treatments simultaneously and made changes quickly. In Dr K' opinion that was unusual practice in mental health services for children and adolescents within the UK. In his oral

evidence Dr K explained that other conditions such as ADHD in a child may look like bipolar disorder. He opined the diagnosis of bipolar disorder was best made over a period of time. He expressed a concern about a diagnosis of SBD/Bipolar NOS (see definition in paragraph 83 below) and a risk of overinclusion of children with emotional dysregulation and family issues. Dr K supported his opinion by referring to the ‘*Maudsley Guidance for Children, Principles for prescribing practice in childhood and adolescence*’ (14<sup>th</sup> Edition) which states:

*“Diagnosis can be difficult in children and co-morbidity is very common. Treatment should target key symptoms. While a working diagnosis is beneficial to frame expectations and help communication with patient’s and parents, it should be kept in mind that it could take some time for the illness to evolve”.*

51. Ms Bucklow submitted that Dr Zamar’s approach was not justified by the urgency of Patient D’s situation.

52. Mr Brassington submitted that there was no evidence that Dr Zamar did not consider these points. He submitted that when Dr K asserted in his report that “*Dr Zamar failed to pick up on or follow Dr [E] worries about the complexity of Patient [D’s] case*” he failed to provide any explanation for this assertion. He submitted that when it was put to Dr K that Dr Zamar had regard to the complexity of the case as set out in Dr E’s email, he responded “*I hope so*” and could not say that Dr Zamar had not considered the points raised by her. Dr Zamar gave evidence in his statement and in oral evidence that he had considered the points raised by her. It was submitted that he had access to Dr E’s notes from 2019 so must have been well aware of both the complexity and context of Patient D’s case. Dr Zamar had treated XXX which added to his knowledge and awareness of the family context.

53. Paragraph 5(a) to (d) of the Allegation states that between 25 February and 17 May 2022, Dr Zamar prescribed Patient D the medication as set out in Schedule 1, and he: (a) acted outside of his competency; (b) disregarded the opinion of a child and adolescent psychiatrist; (c) prescribed high dose Levothyroxine, which was contraindicated for Patient D, a child, who had normal thyroid function; and (d) simultaneously prescribed and/or made fast changes to Patients D’s Alprazolam and Quetiapine dosages.

54. In relation to paragraph 5(a) of the Allegation it is agreed that Dr Zamar was and is not a child and adolescent psychiatrist and has not undergone the specialist training for that position. It is not disputed that when Dr Zamar took over Patient D’s care she was 16 years old. Ms Bucklow submitted that Dr K’ opinion was that if Dr Zamar was to be involved, Dr K

would have expected a child and adolescent psychiatrist to be the lead clinician with Dr Zamar advising.

55. Ms Bucklow submitted that Dr Zamar inappropriately took over as the sole provider of psychiatric care and stepped back from any input from a child psychiatrist, CAMHS and Patient D's professional network. Ms Bucklow submitted that any urgency in Patient D's case did not explain the decision to exclude the input of anyone qualified in child and adolescent psychiatry.

56. Mr Brassington submitted that Dr K gave no evidence to support paragraph 5(a) beyond the simple statement of fact that Dr Zamar was not a child and adolescent psychiatrist. He submitted that Dr K did not explain in his report or in evidence why this should mean Dr Zamar was not competent to prescribe for Patient D.

57. In relation to Alprazolam, Mr Brassington submitted that this was prescribed to provide relief from panic attacks, that Dr Zamar relied on the American Psychiatric Association ('APA') Practice Guideline *For The Treatment of Patients With Panic Disorder*. He submitted that no recommendations are made in the BNF or BNFC regarding the prescription of Alprazolam for the treatment of panic attacks; and that the preface to the BNF (Exhibit AZ72) states that that it should be "*supplemented as necessary by specialised publications*" such as the APA *Guideline For The Treatment of Patients With Panic Disorder*.

58. In relation to the selection of a dose, he submitted that the BNF states that "*In all circumstances, it is important to consider the patient in question and their physical condition and select the dose most appropriate for the individual*". He submitted that The APA Practice Guideline stated that: "*For patients who have not taken Alprazolam in the past, the starting dose should be 0.25 mg three or four times daily. The dose should be titrated up to 2-3 mg/day over the first week or two, but an increase to as high as 5-6 mg/day may in rare instances be necessary to obtain symptom control.*" He submitted that the prescription of Alprazolam to Patient D was in keeping with this Guideline.

59. The Tribunal accepted that in the majority of young people under 18 years with serious mental health problems were treated by a child and adolescent psychiatrist. The Tribunal noted the NHS guidance on moving on to adult mental health services (AZ56) which contained the following: '*This can happen when you are around 18 but happen any time between 16 and 25 depending on your personal circumstances and what's available in your local area.*'

60. Paragraph 5(b) of the Allegation alleged that Dr Zamar disregarded the opinion of a child and adolescent psychiatrist. Ms Bucklow submitted that he disregarded the opinion of Dr E as set out in her emails on the 13, 14 and 15<sup>th</sup> of February 2022. Ms Bucklow submitted that Dr Zamar's responses to these emails showed a disregard for her opinion regarding complexity and the importance of dealing with the family dynamic and of Dr E's opinion on the appropriate approach to take in transferring Patient D's care.

61. Paragraph 5c of the Allegation alleged that Dr Zamar prescribed high dose Levothyroxine, which was contraindicated in a child with normal thyroid function. There was no dispute that a contraindication in medicine relates to a treatment that should not be used because of the risk of harm to a patient. Ms Bucklow submitted that Patient D was a child in her developing years with normal thyroid function. Dr K opined it was seriously below standard for Dr Zamar to prescribe Levothyroxine to Patient D in such circumstances.

62. Ms Bucklow submitted that Levothyroxine was a medication only licenced for use in patients with hypothyroidism. She also submitted that Dr Zamar accepted the use of Levothyroxine in Patient D was off-licence, as it is with any patient being treated with the Zamar Protocol. Ms Bucklow further submitted that in respect of prescribing medication for unlicensed use, this is permitted, but the prescriber should be able to justify and feel competent in using such medicines.

63. Ms Bucklow submitted that whilst Dr Zamar might have experience in prescribing Levothyroxine to adults, he had not established his experience or the safety of prescribing it to children or those who haven't completed development. The GMC pointed to the risk factors when prescribing Levothyroxine.

64. Mr Brassington submitted that Dr K's evidence that administering Levothyroxine to a child of this age '*did not feel right*' and "*not what I'd do*" was way short of proving that it was contraindicated. He submitted that the 13<sup>th</sup> edition of the Maudsley Prescribing Guidelines cited a study whereby Levothyroxine was used to treat bipolar disorder in a 13 year old.

65. He submitted that when Dr K was invited to explain what (if anything) was wrong with the evidence provided by Dr Zamar in Appendix 6 supporting his use of Levothyroxine Dr K could point to no error in the logic of the document or the evidence base relied on.

66. In relation to paragraph 5(d) of the Allegation, that Dr Zamar simultaneously prescribed and/or made fast changes to Patients D's Alprazolam and Quetiapine dosages, Ms Bucklow submitted that the expert opinion of Dr K was that there was a role for either

Alprazolam or Quetiapine to reduce emotional dysregulation in children. However, he did not agree with the simultaneous prescribing of different classes of medication in children and adolescents (referred to as polypharmacy).

67. Ms Bucklow (relying on the evidence of Dr K) submitted that when Dr Zamar instigated the withdrawal of Fluoxetine, with the simultaneous initiation of high dose Levothyroxine, rTMS, Quetiapine and Alprazolam that the changes to the Alprazolam and Quetiapine were too fast and inappropriate. Dr K in his oral evidence, was concerned that in taking this approach it was not possible to know which drug was having what effect and to what extent.

68. Ms Bucklow pointed to Dr K's opinion that there was a need to go slow and stay slow. She submitted that this opinion was supported by the Maudsley Guidelines (14<sup>th</sup> Edition) for prescribing in children:

- Begin with less, go slow and monitor efficacy and adverse reactions;
- Gradually increase dose as needed, and finish at a dose that produces adequate symptom control;
- Allow time for adequate trial of treatment, children will require longer periods of treatment before responding;
- Where possible, change one drug at a time, make changes to one drug at a time and attempt to remove a drug, when adding a new drug, if possible.

69. In relation to Quetiapine and Alprazolam Mr Brassington submitted that the BNFC guidance was that the amounts were neither excessive nor changed quickly. He submitted that Dr K in his oral and written evidence repeated that *“most child and adolescent psychiatrists would avoid Polypharmacy”* and that these statements were insufficient to establish that it was inappropriate to simultaneously prescribe Quetiapine and Alprazolam.

70. He submitted that even if it is correct that most would avoid polypharmacy it would directly follow that some would use polypharmacy. He submitted that Dr K had not said that no reasonable psychiatrist would prescribe more than one medication. He submitted that Dr Zamar, when he gave evidence, provided a detailed and evidence-based explanation of how and why he used the two medications for the different purposes for which each was prescribed. He submitted that Dr K said that most child psychiatrists would start slow and go slow with medication: he did not say that no reasonable psychiatrist would make the changes that Dr Zamar made.

71. In respect of Quetiapine Ms Bucklow submitted that Dr K did not support its use for sleep, and that in a child 25-50mg would have been sufficient for sedation. Ms Bucklow submitted that the BNFC guidance on which Dr Zamar relied to support his doses and the rate of increase, applied to children with bipolar mania and not sleeping difficulties. She also submitted that these guidelines do not support his rate of increase when prescribing Quetiapine to Patient D.

72. Mr Brassington submitted that when Dr K was challenged that the increases of Quetiapine were in line with (or slower than) the recommendations in the BNFC, Dr K could not provide any cogent explanation as to why the changes were fast. His evidence was that such prescription was not normal practice and he wouldn't have made such increases. He submitted that it did not follow that the changes were objectively fast. He submitted that it was clear from the BNFC that they were not.

73. In respect of Alprazolam, Ms Bucklow submitted that according to the BNFC it was not intended for use in the UK for patient under 18 years of age. Mr Brassington submitted (1) that this was prescribed to provide relief from panic attacks, (2) that Dr Zamar relied on the APA Practice Guideline, (3) that no recommendations are made in the BNF or BNFC regarding the prescription of Alprazolam for the treatment of panic attacks, and (4) that the preface to the BNF (exhibited as Exhibit AZ72) stated that that it should be *"supplemented as necessary by specialised publications"* such as the *APA Guideline For The Treatment of Patients With Panic Disorder*.

74. Mr Brassington submitted that in relation to the selection of a dose, the BNF stated that *"In all circumstances, it is important to consider the patient in question and their physical condition and select the dose most appropriate for the individual"*. He submitted that The APA Practice Guideline stated that: *"For patients who have not taken Alprazolam in the past, the starting dose should be 0.25 mg three or four times daily. The dose should be titrated up to 2-3 mg/day over the first week or two, but an increase to as high as 5-6 mg/day may in rare instances be necessary to obtain symptom control."* He submitted that the prescription of Alprazolam to Patient D was in keeping with this Guideline.

### The Relevant Legal Principles

75. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation, Dr Zamar does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the

balance of probabilities, i.e., whether it is more likely than not that the events occurred.

76. The Tribunal gave consideration to all the written and oral evidence adduced and the submissions. A number of paragraphs of the Allegation were withdrawn at the commencement of these proceedings. The Tribunal had read documents which related or included reference to those withdrawn paragraphs and in addition one of the GMC witnesses raised matters that were not in the agreed GMC bundle. As a result, the Tribunal directed itself to put out of its mind any material that did not relate the paragraphs of the Allegation it was now asked to determine.

77. In considering the evidence, the Tribunal must have regard to the whole of the evidence and form its own judgement about the witnesses and which evidence was reliable, and which is not. The Tribunal must judge the doctor's evidence by precisely the same fair standards as it applies to the other evidence in this case.

78. The Tribunal will decide what weight it attaches to each aspect of that evidence. The Tribunal does not have to determine every issue that has arisen during the hearing, only such matters as are necessary to be able to say whether each paragraph is proved.

79. The Tribunal must consider each paragraph of the Allegation separately on its merits. It is possible, depending on the circumstances, that the Tribunal decision on one paragraph might assist it coming to a conclusion on another paragraph. Nevertheless, the Tribunal should reach a separate, independent decision on each.

80. In terms of inferences, inferences may be properly drawn from the evidence. The Tribunal must be mindful that when drawing inferences, it has been able to safely exclude as less than probable any other possible explanations given by the doctor. The Tribunal should only draw an inference if it can safely exclude other possibilities.

81. In terms of good character, the doctor is a good character. The Tribunal therefore should remind itself that the doctor is more likely to be telling the truth in his evidence and is less likely to have behaved in the way set out in the Allegation.

82. With regard to expert evidence, this is there to assist the Tribunal to understand the technical aspects of the evidence. Unlike witnesses of fact, experts are entitled to give their opinion on that evidence and the standard of care provided.

### **The Tribunal's Analysis of the Evidence and Findings**

### Sub threshold bipolar disorder and rapid cycling bipolar disorder

83. Dr Zamar gave evidence that he specialised in diagnosing SBD. He set out his understanding of SBD in his witness statement. His written and oral evidence was that patients with SBD disorder do not experience the distinct and discrete episodes of mania/hypomania and depression that occur in Bipolar I and Bipolar II. The term *'Subthreshold Bipolar disorder'* does not appear in the International Classification of Diseases, Version 10 (ICD-10). The Tribunal was satisfied that when Dr Zamar referred to Subthreshold Bipolar disorder, he was referring to what is otherwise known as *'Bipolar Affective Disorder, unspecified'* which appears in the ICD-10 coded as F31.9 or Bipolar Disorder Not Otherwise Specified (BD-NOS for short) in Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> Edition (DSM-5). Dr Zamar exhibited a National Institute of Mental Health (NIMH) press release to further explain BD-NOS (AZ05): *"Bipolar I is considered the classic form of the illness, in which a person experiences recurrent episodes of mania and depression. People with bipolar II experience a milder form of mania called hypomania that alternates with depressive episodes. People with bipolar disorder not otherwise specified (BD-NOS), sometimes called subthreshold bipolar disorder, have manic and depressive symptoms as well, but they do not meet strict criteria for any specific type of bipolar disorder noted in the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV), the reference manual for psychiatric disorders. Nonetheless, BD-NOS still can significantly impair those who have it."* It was agreed that patients diagnosed with BD-NOS do not meet the criteria for a diagnosis of Bipolar Disorder Type I or Bipolar Disorder Type II. Dr L gave a detailed description of BD-NOS in Appendix 2 of his statement. Dr Zamar gave evidence that the term BD-NOS is no longer in use so the Tribunal has used the term SBD.

84. There is also reference in the evidence to rapid cycling bipolar disorder. The Tribunal heard evidence from Dr Zamar that rapid cycling bipolar disorder is characterized by at least four mood episodes (manic, hypomanic, or depressive) within a 12-month period, with each episode demarcated by a switch to opposite polarity or a period of remission. This pattern can occur with bipolar I or bipolar II disorder and is often associated with more severe symptoms and a higher risk of suicide. It was not disputed that treatment for rapid cycling bipolar disorder is complex and may require a combination of medications and other interventions.

### Bipolar disorder in the UK

85. Dr Zamar's evidence was that SBD is a common and highly disabling condition with a significant mortality risk, the prevalence of which he argued was under-recognised by clinicians. He exhibited at AZ04 a NIMH press release of May 2007 stating that bipolar disorder was under-recognised and undertreated (referring to a study exhibited at AZ05). He exhibited as AZ07 a study (published by the British Journal of Psychiatry in 2011) which reported that between 3.3 and 21.6% of primary care patients with unipolar depression may have an undiagnosed bipolar disorder.

86. He exhibited at AZ16 the Bipolar Society's report 'Bipolar Mind Matters' (November 2022) to support his contention that bipolar disorder was under-diagnosed and that current medical practice was failing patients. He referred the Tribunal to the Forward from Professor P who wrote: *'The findings of the Bipolar Commission have shocked me out of my complacency. People with bipolar should be very angry about the policy failures of the past two decades.'* Dr Zamar exhibited various studies indicating that bipolar disorder and SBD in particular appeared to be more prevalent and diagnoses less frequent. He quoted from the 2018 Cardiff Study: *"Bipolar disorder is a complex mood disorder that can be viewed as a spectrum condition. A growing body of research suggests that it is under recognised in clinical practice and often misdiagnosed as recurrent major depressive disorder. Estimates of the mean delay between first onset of mood symptoms and receiving a correct bipolar diagnosis are in the region of 10 years. Certain subgroups of individuals with depression, such as those with early-onset depression and those with severe or treatment-refractory depression, appear to have the highest rates of unrecognised bipolar disorder.'*

### Bipolar disorder and young people

87. Dr Zamar exhibited various studies indicating the onset of bipolar disorder at an early age. One study found 50% of people affected by bipolar disorder reported the onset of their symptoms between the ages of 11 and 20 (Appendices 1 and 7 with exhibits AZ11 AZ59-61, AZ63 and AZ67 which referred to a peak onset of 15-19 years). At Exhibit AZ 58 he quoted that researchers found that positive screening for bipolar disorder was more common in younger age groups with 3.4% of 16-24 year olds. He exhibited at AZ08 a study finding that individuals with bipolar disorder reported that the illness manifests itself early in life but that accurate diagnosis lagged by many years.

88. The Tribunal noted that the Bipolar Society report 'Bipolar Mind Matters' at AZ16 quoted a 2014 study (at AZ17) that found 16-24 year olds were eight times more likely to screen positive for bipolar disorder than those age 65 or older. Dr L in his report dated 27 August 2025 was of the opinion that there was a plurality of views as to the age of onset of

bipolar disorder. He quoted a research study stating that a majority 45% of participants displayed an average age at onset of 17.3 years. He quoted the 2014 Adult Psychiatric Morbidity Survey found the peak age of onset between the ages of 15 and 19.

### **Dr Zamar's expertise**

89. Dr Zamar asserts expertise in the treatment of bipolar spectrum disorders using the Zamar Protocol and its combination of high dose Levothyroxine and rTMS. The GMC's case in relation to the Zamar Protocol (based on Dr K's evidence) was that it was a form of treatment without a solid scientific basis and inappropriately applied to Patient D.

90. Dr Zamar's case was that it was an innovative and valid form of treatment which was recognised both in the UK and abroad. The Tribunal noted that the CQC inspection in June 2023 (AZ1) rated Dr Zamar's Centre with an overall rating of 'Good' with the effectiveness of services was rated as 'Outstanding'. It noted that Dr Zamar had given presentations on his treatment approach. In 2021 he presented to the World Psychiatric Association World Congress of Psychiatry. In 2022 he presented to the European Congress of Psychiatry, the European Society of Medicine General Assembly and the World Psychiatric Association Thematic Congress. In 2024 he presented to the 9th Congress on Neurobiology, Psychopharmacology & Treatment Guidance and to the World Federation of Societies of Biological Psychiatry: The World Congress, Of Biological Psychiatry. He contributed, in respect of Levothyroxine and rTMS, to the Task Force on Neuroprogression-Consensus Report, intended to be submitted as a review article to the World Journal of Biological Psychiatry.

91. In September 2025 he presented at The World Congress of Biological Psychiatry in Berlin, a symposium with Professor R of Loyola University, USA and Professor Q of Deakin University School of Medicine, Australia. He is a member of the European Psychiatric Association (EPA) Neuromodulation group and a Member and Secretary of The World Psychiatric Association (WPA) Immunopsychiatry group.

92. The Tribunal noted that Dr Zamar stated that he was responsible for introducing rTMS and external Trigeminal Nerve Stimulation (eTNS) to the UK. He stated that in relation to rTMS he has provided advice to the Advanced Interventions Service of the University of Dundee, the University of Monterrey in Mexico, and a Swedish Parliament delegation for setting up rTMS units in Sweden. He reported that his Clinic was visited by an Eastern European delegation in 2015 to advise on rTMS treatment centres in these countries. The Tribunal found no case to answer in relation to the paragraph of inappropriate use of rTMS in relation to Patient D so did not need to refer further to the use of rTMS in her case.

93. The Tribunal is only concerned with the disputed paragraphs of the Allegation about the diagnosis and medication prescribed to Patient D. Dr Zamar quoted an article from a former patient and two case studies (published in the Journal of the Royal Society of Medicine at AZ31) indicating the success of his treatment. He accepted that there is little research on the treatment of SBD. He exhibited studies he had done of 20 patients (published in the International Journal of Psychiatry Research AZ34) and then 55 patients (published in the Journal of Clinical Medicine AZ35) quoted in the Maudsley Guidelines 15<sup>th</sup> Edition at AZ37 to illustrate the effectiveness of his treatment. The Tribunal noted that Dr Zamar's studies would have had to have been peer reviewed prior to publication. In addition, he exhibited studies about the use of Levothyroxine for treating bipolar disorder (AZ48, AZ51-53). He exhibited Terrence Ketter's handbook on Diagnosis and Treatment of bipolar disorders (AZ50) which describes starting the prescription of Levothyroxine for the treatment of mood disorders at 50 mcg per day and increasing the prescription as necessary and tolerated every 3-7 days by 50 mcg per day to as high as 500 mcg. He also exhibited studies showing the relative safety and lack of adverse side effects for patients prescribed Levothyroxine (e.g. AZ51-53).

94. The Tribunal noted the comments of Dr O, Dr Zamar's assessor, who was of the opinion that Dr Zamar's access to recent research vindicated his treatment approaches. In Dr O's opinion, Dr Zamar was providing world class psychiatric care. Dr O stated that he had learnt so much from Dr Zamar despite having worked as a substantive Consultant Psychiatrist with the NHS since 2010. Whenever Dr O had questions about the science or the scientific rationale about differential diagnosis, tools used, management approaches, Dr Zamar had a patient, measured and incredibly well reasoned approach to his answers. Dr O found it pleasing that Dr Zamar's insights and contribution to psychiatry are being recognised. In the discussion of 28 February 2025 Dr O recorded: *'Dr Zamar is one of the most impressive doctors, certainly psychiatrists I have ever met. I am quite shocked he is under investigation looking at the quality of the work and rigour of his approach.'*

### **Dr Zamar's diagnostic method**

95. Dr Zamar's diagnosis of patients included screening patients before he interviews them. In the case of Patient D he used:

- (1) the Impact of Event Scale questionnaire, which he used to screen for possible PTSD;

- (2) the HCL-32 (Hypomania Checklist) which he described as a reliable screening instrument. Dr Zamar exhibited various studies indicating the accuracy of the HCL-32 (e.g. Exhibits AZ19 and AZ63). Dr Zamar referred to the 2018 Cardiff study that indicated that HCL-32 could distinguish between bipolar disorder and major depressive disorder with reasonable precision (Exhibit AZ07). He exhibited research that HCL-32 was valid for use in adolescence (Exhibit AZ63);
- (3) the Beck Depression Inventory (BDI) and exhibited a research paper that indicated that it was a reliable and useful tool to screen adolescents for depression (Exhibit AZ62);
- (4) the Beck Anxiety Inventory, which was used to screen for anxiety and assess severity;
- (5) the Sheehan Disability Scale, which he used to assess the extent of the impairment of her functioning.

96. Dr L in Appendix 2 of his statement stated that *‘for unclear reasons psychiatry, outside of a research arena, has not embraced or welcomed the use of standardised measures in the same manner as the other main specialty that deals with behavioural abnormalities and health, psychology.’* In Dr L’s opinion the use of standardised and validated scales is responsible for improved outcomes and research, as it allows better comparisons of data, and the application of observation, inference and hypothesis testing.

97. In his report, dated 27 August 2025, Dr L was of the opinion that when it specifically came to bipolar disorder (which is recognised as being not adequately diagnosed, with a long delay between symptom onset and diagnosis) the use of questionnaires increased detection rates, diagnostic accuracy, and reduced the diagnostic lag. It seemed to him that this was evidence based practice that was in the best interests of patients.

98. In relation to the evidence provided by Dr Zamar on the general picture of an underdiagnosis of bipolar disorder the Tribunal took into account that in the medical profession there was a continuous debate as to the diagnosis and treatment of medical and psychiatric conditions. The Tribunal took note that responsible bodies (such as the Bipolar Society), responsible individuals (such as Professor P) and research papers published in responsible journals argued that (1) bipolar disorder was underdiagnosed particularly amongst young people; (2) the onset of bipolar disorder was at an earlier stage than others argued; and (3) current medical practice was not meeting the diagnostic and treatment needs of patients in terms of bipolar disorder.

99. In terms of Dr Zamar's use of questionnaires as an initial part of the process, the Tribunal was satisfied that they were evidence based and methods that a reasonably competent psychiatrist might choose to use.

100. The Tribunal considered the credibility and reliability of the respective experts: Dr K and Dr Zamar. The Tribunal took into account the duties expected of an expert: to be independent, objective and unbiased, to give opinion within their area of expertise, to state the facts and assumptions upon which they base their opinion and not to omit material which detracts from that opinion.

101. In relation to Dr K the Tribunal noted his holistic approach to diagnosing and treating children and young people. It noted that he took account of a wide range of factors in his practice. However, the Tribunal had concerns about his credibility and reliability. He repeatedly responded to questions with 'this is what we do' rather than referencing research that supported his approach. He relied on his clinical experience and liaising with his peers. In terms of criticising Dr Zamar his evidence was often 'it is not what we do' rather than specifically addressing the detail of what happened to Patient D. He had little experience in diagnosing and treating SBD and bipolar disorder in general compared to Dr Zamar (although Dr Zamar's experience was with adults). Dr K said in evidence that he had diagnosed less than 5 patients with bipolar disorder in his 20 year career as a child and adolescent psychiatrist and that he had not diagnosed any cases of SBD.

102. Dr K relied on the NICE guidelines to support his opinion but then accepted that they did not provide any guidance regarding the treatment of SBD. He also relied on an article that referenced a number of papers, where treatment options had been debated, but he did not identify any conclusions in those papers that assisted his case. The evidence he relied upon, in the Tribunal's judgement, did not materially support his opinion.

103. The Tribunal was not impressed by Dr K's response to the Bipolar Minds Matter report. When challenged that this report was a plea to guard against complacency and that bipolar disorder was under diagnosed and subject of delayed diagnosis, Dr K came across as dismissive of it and the implications for current practice. Aspects of his evidence were dogmatic and inflexible. He was overly dismissive of the usefulness of screening tools. It appeared to the Tribunal that it was not unreasonable to combine clinical experience with reflection on research findings that might improve clinical practice and outcomes.

104. Dr K when criticising Dr Zamar's prescription of Levothyroxine did not appropriately respond to the evidence base supporting its use in Appendix 6 of Dr Zamar's statement.

When challenged about polypharmacy not always being inappropriate. Dr K suggested he had been talking about “*co-pharmacy*” and that exhibit AZ 82 in his judgment introduced more confusion rather than providing clarity.

105. In its determination on the no case to answer submission in Annex C the Tribunal gave leeway to Dr K in changing his opinion about rTMS which led to the Tribunal finding no case to answer in relation to paragraph 5(e). However, the Tribunal notes that the evidence which Dr K referred to as the basis for changing his mind was evidence within Dr Zamar’s bundle at AZ74 which Dr K failed to pick up earlier. Dr K also appeared to be unaware of the NICE guidance that rTMS was safe at 1Hz and 20Hz. This led the Tribunal to having a degree of discomfort that Dr K was not as thorough as he should have been in developing and giving his opinion. He did not appear to have taken account of the evidence supporting the validity of rTMS as a treatment.

106. In relation to Dr Zamar the Tribunal found him a thoughtful, credible and convincing witness. On occasions he did not directly answer questions put to him in cross examination, but this did not persuade the Tribunal that his evidence was unreliable. The Tribunal agreed with the submission that he may have been desperate to explain himself with reference to the evidence base. The Tribunal was impressed by Dr Zamar’s efforts to provide research papers for each aspect of his approach to diagnosis and treatment generally and to his diagnosis and treatment of Patient D specifically. He was able to point to evidence that justified his opinions. He was consistently open in his responses. He did not deflect or avoid any question. For example, he gave a full explanation as his approach to the four step approach for dealing with bipolar. The Tribunal has already noted Dr Zamar’s international reputation. The Tribunal has noted that one of Dr Zamar’s research studies is referenced in the Maudsley Guidelines 15<sup>th</sup> Edition.

#### Paragraph 4

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

108. In relation to paragraph 4 the Tribunal found no direct evidence to support it. The GMC’s case appeared to invite the Tribunal to infer a lack of consideration as to complexity and context because Dr Zamar made the wrong diagnosis (though this was not a part of the Allegation), made his diagnosis too quickly and with preconceived ideas.

109. The Tribunal was unable to accept that any such inferences could be made. Dr K when asked if Dr Zamar had considered complexity and context replied ‘I hope so’ which is a long way short of ‘he did not’. Dr Zamar gave evidence with reference to the records and the literature which demonstrated that he had carefully considered the complexity and context of the case. He had access to Dr E’s records since 2019. He had treated XXX so had some prior knowledge of the family dynamics. In the correspondence Dr E gave context for Patient D’s condition which Dr Zamar acknowledged in his reply. Dr E supported the transfer to Dr Zamar’s care. She was copied in on the correspondence setting out Dr Zamar’s diagnosis and treatment. The Tribunal found no evidence that she objected to or raised concerns after Dr Zamar commenced his treatment of Patient D.

110. The Tribunal particularly noted the correspondence in Patient D’s medical records which are consistent with Dr Zamar considering both complexity and context. There was a volume of correspondence involving Dr E and Dr Zamar copied to other professionals that supported Dr Zamar’s case. Dr Zamar referred to Patient D’s history of panic attacks, which Dr K agreed was significant. Dr Zamar referred to the research literature that indicated that in those circumstances Patient D was 26 times more likely to develop bipolar disorder. He highlighted the worsening of Patient D’s condition on Fluoxetine (which Dr K agreed had happened). Dr Zamar highlighted the warning about the use of Fluoxetine that it increased the risk of suicidal thinking and behaviour in children and adolescents and young adults taking antidepressants. He highlighted the recommendation in the prescribing leaflet that *“prior to initiating treatment with an antidepressant, patients with depressive symptoms should be adequately screened to determine if they are at risk for Bipolar Disorder”* (which Dr K agreed must be done). Dr Zamar highlighted Patient D’s severe depression, her HCL-32 results (positive for hypomania), and the manic symptoms identified on assessment.

111. Dr Zamar highlighted her complex family dynamics and evidence that this had caused severe PTSD. Dr K agreed that Dr Zamar adequately assessed and examined Patient D. Taking into account the whole of the evidence including that the Tribunal preferred the evidence of Dr Zamar to that of Dr K the Tribunal is not satisfied that Dr Zamar did not consider the complexity and context of Patient D’s case. Though there is no burden on Dr Zamar to prove anything, in light of the totality of the evidence, the Tribunal finds it more likely than not that Dr Zamar appropriately considered the complexity and context of Patient D’s case when on 15 February 2022 he diagnosed Patient D’s condition.

112. Therefore the Tribunal finds paragraph 4 of the Paragraph not proved.

#### Paragraph 5a

113. In relation to paragraph 5a it was accepted that Dr Zamar was and is not a child and adolescent psychiatrist. It is accepted that when he treated Patient D he was not directly monitored by a child and adolescent psychiatrist. The GMC asserted that Dr Zamar excluded others e.g. CAHMS from being involved in Patient D's treatment. The Tribunal found no evidence to back that assertion. To the contrary Dr Zamar copied CAHMS and other professionals into the correspondence so that they were aware of what was happening. The GMC case appeared to be based on the assertion of Dr K that only a child and adolescent psychiatrist could and should have treated Patient D.

114. The Tribunal's judgement is that the above assertion is not enough to prove paragraph 5(a). It is agreed that NHS guidelines allow an adult psychiatrist such as Dr Zamar to treat a patient aged 16 years. Dr E approved the transfer. Dr Zamar kept her and other professionals informed, including Patient D's GP and CAHMS. Dr Zamar evidenced each step of his diagnosis and treatment. He was entitled to prescribe medication to Patient D. Whenever he was uncertain about an aspect of his care he referred the matter to a relevant professional e.g. Dr H, the cardiologist.

115. The Tribunal considered Dr Zamar's approach careful. He referred to the relevant guidelines. He prescribed medication and exhibited his evidence base for doing so by reference to the symptoms exhibited by Patient D when she first saw him and the medical evidence in support of the treatment he prescribed.

116. The Tribunal was not satisfied that paragraph 5a had been proved on a balance of probabilities.

#### Paragraph 5b

117. In relation to paragraph 5(b) it was not clear to the Tribunal whose opinion had been disregarded. The GMC case appeared to be one of inference from correspondence with Dr E. The Tribunal found no basis for inferring that Dr E had expressed any opinion which Dr Zamar disregarded. The Tribunal has found it more likely than not that Dr Zamar understood the complexity and context of Patient D's case. He received and valued the information ('feedback' in Dr Zamar's words) from Dr E. Dr E agreed to the transfer of care to Dr Zamar inconsistent with any assertion that he had disregarded her opinion. The Tribunal found no evidence that she objected to or raised concerns once Dr Zamar commenced his treatment of Patient D. The fact that Dr Zamar reached a different diagnosis to that reached by

professionals involved earlier in Patient D's case does not prove that he disregarded their opinions.

118. The Tribunal was not satisfied that paragraph 5(b) had been proved on a balance of probabilities.

#### Paragraph 5c

119. The Tribunal noted that Paragraph 5c asserts that Dr Zamar prescribed high dose Levothyroxine, which was contraindicated for Patient D, a child, who had normal thyroid function. The Tribunal noted that 'contraindicated' refers to a treatment or drug that should not be used because of the risk of harm to a patient. The Tribunal did not accept the GMC's assertion that if a particular drug or treatment is not the right choice for a patient it is therefore contraindicated. The fact that a drug may have risks or side effects is not of itself sufficient to prove that it is contraindicated. In this context the Tribunal found no evidence that Levothyroxine was contraindicated in Patient D's case.

120. Dr Zamar exhibited a case study involving treating a 13 year old with Levothyroxine which was exhibited in the 13<sup>th</sup> Edition of the Maudsley Guidelines. Though it is one case study it nevertheless contradicts the assertion that Levothyroxine was contraindicated. Dr Zamar provided a rationale and evidence base for his treatment. There was nothing in the BNF stating that Levothyroxine was contraindicated.

121. The Tribunal was not satisfied on the balance of probabilities that paragraph 5c was proved.

#### Paragraph 5d

122. In relation to the paragraph 5d that Dr Zamar simultaneously prescribed Patients D's Alprazolam and Quetiapine it is accepted that he prescribed both medications. The paragraph has an and/or so if the Tribunal applies the 'or' and it is not satisfied as to the fast changes then this means that the agreed assertion of simultaneous prescribing is made out.

123. In relation to the paragraph that Dr Zamar made fast changes to Patient D's dose of Quetiapine the Tribunal notes that BNFC recommends 25 mg twice daily for day 1, then 50 mg twice daily for day 2, then 100 mg twice daily for day 3, then 150 mg twice daily for day 4, then 200 mg twice daily for day 5, then adjusted in steps of up to 100 mg daily, adjusted according to response, usual dose 400-600 mg daily in 2 divided doses.

124. In the Tribunal's judgement Dr Zamar's initial prescribing of Quetiapine was in accordance with that guideline and subsequently he increased Patient D's dose of Quetiapine at a slower rate than is recommended in the BNFC. Hence the Tribunal did not find he made fast changes to the prescription of Quetiapine.

125. He explained his rationale for prescribing Alprazolam to assist with panic attacks. The correspondence and Dr Zamar's oral evidence explained his choice of Alprazolam for Patient D's symptoms of panic and the dosage changes that he made. The Tribunal accepted Dr Zamar's evidence that Patient D had strong suicidal thoughts and that it was imperative for him to act urgently to reduce her distress. He explained why the dosage changes he made were indicated in her case to try and obtain symptom control. Hence the Tribunal did not find he made fast changes to the prescription of Alprazolam.

126. The Tribunal is not satisfied on a balance of probabilities that Dr Zamar made fast changes as alleged so this aspect of the paragraph is not proved. If the paragraph is read as simultaneously prescribed **and** made fast changes to Patient D's Alprazolam and Quetiapine dosages this paragraph is not proved. If the paragraph is read as simultaneously prescribed **or** made fast changes to Patients D's Alprazolam and Quetiapine dosages then the first half of the paragraph is proved and the second part not proved. The Tribunal noted that this limited finding is one that does not appear to be relevant to any issue of misconduct.

#### Paragraph 6

127. In relation to paragraph 6 it is accepted that Patient D was vulnerable because of her mental health. The issue is whether she was vulnerable by virtue of her mental health and by virtue of the fact that she was a minor. In this case there was no specific evidence that Patient D was vulnerable simply because she was aged 16. She was at all times accompanied by a parent. The Tribunal was of the view that a simple assertion that she was vulnerable by virtue of her age is not sufficient to show that on a balance of probabilities she was.

128. The Tribunal therefore determined that paragraph 6 was not proved on the balance of probabilities. The Tribunal recognised that this was something of an academic point given the admission that she was vulnerable by virtue of her mental health and in light of the Tribunal's findings at paragraph 4 and 5 of the Allegation.

#### **The Tribunal's Overall Determination on the Facts**

129. The Tribunal has determined the facts as follows:

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

Patient C

1. ~~On 19 January 2021 you:~~
  - a. ~~failed to carry out a capacity assessment with Patient C;~~ **Withdrawn under Rule 17(6)**
  - b. ~~misdiagnosed Patient C with ‘major depression with subthreshold bipolar feature or unspecified bipolar disorder’.~~ **Deleted under Rule 17(2)(g)**
2. ~~Between 19 January and 19 March 2021 you failed to consider other first line treatments with a stronger evidence base.~~ **Deleted under Rule 17(2)(g)**
3. At all material times Patient C was vulnerable due to their mental health and personal circumstances at the time. **Admitted and found proved**

Patient D

4. On 15 February 2022, you failed to adequately diagnose Patient D’s condition, in that you did not consider the:
  - a. complexity of Patient D’s case; **Found not proved**
  - b. context of Patient D’s case. **Found not proved**
5. Between 25 February and 17 May 2022, you prescribed Patient D the medication as set out in Schedule 1, and you:
  - a. acted outside of your competency; **Found not proved**
  - b. disregarded the opinion of a Child and Adolescent Psychiatrist;  
**Found not proved**
  - c. prescribed high dose Levothyroxine, which was contraindicated for Patient D, a child, who had normal thyroid function; **Found not proved**
  - d. simultaneously prescribed and/or made fast changes to Patients D’s Alprazolam and Quetiapine dosages;  
**Determined and found proved only in relation to simultaneously prescribed Alprazolam and Quetiapine**
  - e. ~~increased Patient D’s Repetitive Transcranial Magnetic Stimulation (‘rTMS’) dose from 1Hz to 20Hz, which was inappropriate in that the:~~

- i. ~~rTMS dose should not have exceeded 10Hz;~~  
**Deleted under Rule 17(2)(g)**
- ii. ~~dosage was suddenly increased.~~  
**Deleted under Rule 17(2)(g)**

6. At all material times Patient D was vulnerable due to their mental health and by virtue of the fact that they were a minor. **Found not proved**

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

### Impairment

#### Legal advice

130. The Tribunal must now determine whether the facts made out amount to misconduct and whether the doctor's fitness to practice is impaired (Rule 17(2)(l) of the Rules). Section 35C(2) Medical Act 1983 states that fitness to practice must relate to one of 6 categories and a doctor can only be found to be impaired if (1) at least one of the categories has been proved; and (2) the doctor is currently impaired.

131. Impairment is a matter for the Tribunal's judgement. There is a 2-stage approach:

- 1. Whether the facts found proved amount to misconduct; and
- 2. Whether that misconduct was serious whereby there should be a finding of impairment.

#### Determination

132. The findings relate to the agreed facts that Patient C was vulnerable and that Dr Zamar simultaneously prescribed Quetiapine and Alprazolam. Neither of these findings disclose misconduct (let alone serious misconduct). None of the categories in s35C(2) have been made out. As a result, the Tribunal does not find that Dr Zamar's fitness to practice is currently impaired.

#### Warning

#### Legal advice

133. Where a Tribunal finds a doctor's fitness to practise is not impaired, it cannot impose a sanction but must consider, under Rule 17(2)(m) of the Rules whether any warning should be imposed.

134. The GMC Guidance on Warnings updated May 2025 paragraph 16 states that a warning will be appropriate if there is evidence to suggest that the doctor's performance has fallen below the standard expected to a degree warranting a formal response from the Tribunal. A warning is appropriate where: (1) there has been a significant departure from Good Medical Practice, or (2) there is a significant cause for concern following an assessment of the doctor's performance.

**Determination:**

135. The Tribunal determines that a warning is inappropriate in Dr Zamar's case since its determination on the facts do not disclose any departure (let alone a significant one) from GMP or disclose any concern (let alone a significant one) as to Dr Zamar's performance. There is therefore no basis to issue a warning and no warning will be imposed.

**Interim orders decision:**

136. The Tribunal revokes the interim order made previously.

**ANNEX A – 28/10/2025**

**Application to admit evidence**

137. On behalf of the GMC, Ms Bucklow made an application pursuant to Rule 16(A) of the Rules for evidence that supported the GMC case to be admitted.

138. The evidence in question was a bundle of some 2000 pages of patient medical records. These records had previously been sent from the GMC to Dr Zamar's legal team for it to propose any redactions. Dr Zamar's legal team had applied their proposed redactions and had then sent them back to the GMC. Due to software issues and security on the GMC server, the GMC was unable to open the returned document. This document had also been sent to Ms Bucklow, who had been able to open the file but unable to save or amend it.

139. On behalf of the GMC, Ms Bucklow submitted that a legal argument would be raised in relation to this document. In order for the Tribunal to consider any legal argument, the Tribunal would need a document to look at, and all parties should have a copy of the bundle that was identical.

140. On behalf of Dr Zamar, Mr Brassington submitted that the GMC was only just beginning to understand this case and the reason there was not an agreed set of medical records was because the GMC did not know which medical records it wanted to rely on. Mr Brassington suggested that the majority of the medical records were irrelevant and it would not be of assistance to the Tribunal to receive nearly 2000 pages of dense medical records to go through. He had suggested that the GMC first identify to Dr Zamar's legal team what it wanted from that bundle.

141. The Tribunal considered three options. The first was to ask parties to suggest a realistic timetable that accommodated the service of the medical records (if the parties agreed they should be admitted) and the appropriate timetable for submissions and decision as to admissibility of any records in relation to which the parties had not been able to reach agreement. The rescheduling of the expert witnesses to allow the case to be completed within the current listing could then be considered.

142. The second option was to refuse the GMC's application and rule that only evidence filed in time for the start of the hearing on 30 September 2025 plus the joint expert report should be admitted.

143. The third option was to admit the medical records as redacted by Dr Zamar.

144. Ms Bucklow submitted that the Tribunal should adopt option 1. Mr Brassington submitted that the Tribunal should adopt option 3.

145. The future availability of the experts was obtained in case the Tribunal determined to follow option 1 and the witnesses needed to be re-timetabled.

The parties to the best of their knowledge confirmed that the GMC experts did not refer to any medical records not set out in Dr Zamar's redacted records.

The Relevant Legal Principles

146. The Tribunal took into account Rules 16(A) and 34(1) of the Rules:

*'16(A) (1) Paragraph (2) applies where, in a matter referred to the MPTS for them to arrange for consideration by a Medical Practitioners Tribunal under rule 17, 22 or 24 (as the case may be) on or after the relevant date, a party fails to comply with—*

*(a) these Rules, or*

*(b) a direction which was issued on or after that date by the Tribunal or the Case Manager.*

*For these purposes, the "relevant date" is the date this provision comes into force.*

*(2) Where there is a failure referred to in paragraph (1), a Medical Practitioners Tribunal may in respect of that failure—*

*(a) draw adverse inferences;*

*(b) refuse to admit evidence where the failure relates to the admissibility of that evidence; and*

*(c) award costs in accordance with rule 16B (a costs award).*

*34(1) The Committee or a Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law.'*

147. The Tribunal also took account of the case of *Arowojolu v GMC* [2021] EWHC 2725 (Admin), which provides that the Tribunal must ensure that it assesses the impact of admitting the evidence or otherwise upon the public interest, as well as any prejudice caused to the practitioner. The balance of fairness and relevance should be considered in light of the position of all parties whilst holding the overarching principles as the Tribunal's predominate purpose. The predominant purpose of the Tribunal is to protect, promote and maintain the health and safety of the public and public confidence in the medical profession.

## The Tribunal's Decision

148. The Tribunal considered each of the options available to it. It discounted option 2 since neither party advocated it. There was a risk that it would deprive the parties and the Tribunal of any access to the medical records, as well as a risk of injustice and unfairness to the parties. Bearing in mind its predominant purpose to uphold the statutory overarching objective, the Tribunal was of the view that this was more likely to be achieved if the medical records were available in some format to the parties and to the Tribunal.

149. The Tribunal next considered option 1. It took into account that while this option was fairer to the GMC, it had significant disadvantages. It would involve vacating the current witness timetable to accommodate legal argument on 6 October 2025 and then the process of decision making and written reasons which might take up 7 and 8 October 2025. While the expert witnesses were each available on various future dates before the scheduled end of the hearing on 31 October 2025 these dates did not readily align. It was likely that this option would result in a series of days where no evidence could be heard. There was a real risk that the proceedings could not be concluded and would either go part-heard or have to be reheard by a different tribunal on a future date. There would then a likely lengthy delay to reconstitute the Tribunal or arrange a fresh hearing.

150. The Tribunal also noted that the issue of the medical records had long been known to the GMC. The C1 pre-hearing certificate completed by the GMC, dated 15 May 2025, referred to the difficulties with the medical records and the potential difficulties with the filing of an agreed bundle by 19 September 2025, yet in the succeeding four months failed to resolve those difficulties. The certificate suggested that the first three days of this hearing could be taken up with legal argument but this did not occur as the parties tried and failed from 30 September to 3 October 2025 to reach agreement. The Tribunal bore in mind that the burden is on the GMC to prove its allegations and present its evidence to satisfy that burden and the standard of proof. In terms of the medical records, it had failed to complete the preparation of its case in a timely manner. The Tribunal was unclear as to what, in particular, was the substance of the GMC's submission that option 1 was essential to its case and that option 3 was unfair and inappropriate.

151. The Tribunal considered that option 3 had the advantage of enabling the current witness timetable to be followed, unlike the risks posed by option 1. This made it far more likely that the case could be concluded within the timeframe allowed. Option 3 enabled the parties and the Tribunal to be supplied with the medical records albeit in a format redacted by Dr Zamar. On the information available to the Tribunal the redactions were not such that the GMC was put to a clear disadvantage. The GMC experts did not appear to refer to any medical record not sufficiently disclosed in Dr Zamar's redacted records. The Tribunal

reminded itself and the parties that matters of evidence were kept under constant review. New considerations might arise as the proceedings progressed. It was open to either party to make an application to admit new evidence if that party considered it essential to its case. The Tribunal could then consider such an application on its merits having heard from both parties and applying the overriding objective. If circumstances emerged that made it appropriate to admit a medical record which had, hitherto, been redacted, the Tribunal could consider t These factors limited the potential for unfairness to the GMC of choosing option 3.

152. Having carefully balanced the options the Tribunal determined to adopt option 3 for the reasons set out above.

## **ANNEX B – 28/10/25**

### **Application to amend the Allegation**

153. On behalf of the GMC, Ms Bucklow made an application pursuant to Rule 17(6) of the Rules, that some paragraphs of the Allegation be amended.

154. The proposed amendments were:

1. On 19 January 2021 you:
  - a. failed to carry out a capacity assessment with Patient C;
  - b. misdiagnosed Patient C with ‘major depression with subthreshold bipolar feature or unspecified bipolar disorder’.
5. Between 25 February and 17 May 2022, you prescribed Patient D the medication as set out in Schedule 1, and you:

...

  - d. made fast changes to Patients D’s Alprazolam/Quetiapine dosages; simultaneously prescribed and/or made fast changes to Patients D’s Alprazolam and Quetiapine dosages;

155. Ms Bucklow submitted that paragraph 1(a) of the Allegation had originated from a criticism from expert witness, Dr J. However, whilst Dr J stated that a capacity assessment should have been carried out, elsewhere in his report he accepted there was no evidence that Patient C lacked capacity. Therefore it could not be established that not carrying out a capacity assessment on Patient C was a failing. Additionally, the foundation upon which Dr J had reached his opinion was based on matters no longer before the Tribunal, and could not be sustained.

156. Ms Bucklow then addressed the Tribunal on the proposed amendment to paragraph 5(d) of the Allegation. She submitted that the current wording included a forward slash between the two medications and was unclear. Clarity was needed as to whether the Tribunal was required to assess and determine whether, individually, each medication was increased too fast or whether it was required to find both were increased too fast. Additionally, in its current form this particular did not fully encompass the failing identified by the expert witness in respect of the two medications.

157. On behalf of Dr Zamar, Mr Brassington submitted that there was no objection to the amendment of paragraph 1 of the Allegation, and it was appropriate.

158. Mr Brassington submitted that it was not agreed that the amendment of paragraph 5(d) was simply an amendment. Rather, there was now an additional allegation of polypharmacy that had not been addressed in Dr Zamar's witness statement. Accordingly, a supplemental witness statement would need to be provided by Dr Zamar to deal with what was now a different and new allegation, as well as the speed of changes to the medications.

159. Mr Brassington told the Tribunal it was regrettable that this amendment had not been made previously but he would not raise any formal objection to it. Based on the evidence before the Tribunal, it was an amendment that had been properly requested and could be granted without any injustice to Dr Zamar.

The Relevant Legal Principles

160. The Tribunal bore in mind Rule 17(6) of the Rules which states:

*'17(6) 'Where, at any time, it appears to the Medical Practitioners Tribunal that—  
(a) the allegation or the facts upon which it is based and of which the practitioner has been notified under rule 15, should be amended; and  
(b) the amendment can be made without injustice,  
it may, after hearing the parties, amend the allegation in appropriate terms.'*

### The Tribunal's Decision

161. The Tribunal took into account that:

- (a) the first amendment removed an allegation so was of benefit to Dr Zamar;
- (b) the application for the second amendment was not opposed by Dr Zamar;

(c) the amended allegation was one encompassed within the existing written evidence; and  
(d) the Tribunal would allow Dr Zamar to respond to it by filing a further witness statement so the amendment could be made without injustice to him.

162. In all the circumstances, The Tribunal determined that the amendments could be made without injustice to Dr Zamar.

## ANNEX C – 17/10/2025

### Application under Rule 17(2)(g)

163. On day 10 of the hearing, 15 October 2025, following the conclusion of the GMC case, Mr Stephen Brassington, Counsel, on behalf of Dr Zamar, made an application pursuant to Rule 17(2)(g) of the Rules. Rule 17(2)(g) states:

*‘the practitioner may make submissions as to whether sufficient evidence has been adduced to find some or all of the facts proved and whether the hearing should proceed no further as a result, and the Medical Practitioners Tribunal shall consider any such submissions and announce its decision as to whether they should be upheld’.*

### Submissions

#### On behalf of Dr Zamar

164. Mr Brassington submitted that that there was no case to answer in respect of the outstanding paragraphs of the Allegation, namely 1, 2, 4(a)-(b), and 5(a)-(e). The state of the evidence at the close of the GMC’s case was such that, taken at its highest, no reasonable Tribunal properly directed could find the allegations in issue proved.

165. Mr Brassington referred the Tribunal to the test to be applied by the Tribunal is as set out in *R v Galbraith* [1981] 2 All ER 1060 which states:

*(1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case.(Limb 1)*

*(2) The difficulty arises where there is some evidence but it is of a tenuous character, for example, because of inherent weakness or vagueness or because it is inconsistent with other evidence.*

*(a) Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made, to stop the case.*

*(b) Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witness' reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence upon which a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury.'*(Limb 2)

166. Mr Brassington also drew the Tribunal's attention to the case of *R v Shippey (Colin)* [1988] Crim. L.R. 767 (QBD). This provides that taking the prosecution evidence at its highest did not mean "*picking out the plums and leaving the duff behind*". If the evidence of a witness was self-contradictory and out of reason and all commonsense then such evidence is tenuous and suffers from inherent weakness. The Tribunal should not consider that if there are parts of the evidence which go to support the charge then no matter what the state of the rest of the evidence that is enough to leave the matter to a jury.

167. Mr Brassington submitted that if the GMC had not provided *any* evidence upon which the Tribunal could find a particular proved, then the burden of proof had not been discharged and there was no case to answer in respect of that particular or element. Where the GMC has presented *some* relevant evidence, then the Tribunal would move on to address the following questions:

- a. Is the evidence so unsatisfactory in nature that the Tribunal could not find the allegation or element proved?
- b. If the strength of the evidence rests upon the Tribunal's assessment of the reliability of a witness, is that witness so unreliable or discredited that the allegation or element is not capable of being proved?

168. Mr Brassington then addressed the principles governing expert evidence as set out by Cresswell J in *Ikerian Reefer* [1993] 2 Lloyd's Rep.68. He submitted that these are widely accepted as the correct approach to the duties and responsibilities of expert witnesses. Similar principles are set out at Part 35 of the Civil Procedure Rules and Part 19 of the Criminal Procedure Rules, and it was not disputed that they apply to Fitness to Practise Hearings before Regulatory Tribunals. Mr Brassington stated the relevant principles were that:

- a. Expert evidence should be and should be seen to be the independent product of the expert, uninfluenced as to form or content by the exigencies of litigation.
- b. An expert witness should provide independent assistance to the court by way of objective unbiased opinion in relation to matters within their expertise and should not assume the role of an advocate.
- c. An expert witness should state the facts or assumptions upon which their opinion is based. They should not omit to consider material facts or learning, which could detract from their opinion.
- d. An expert report should consider all material facts or learning, including those, which might detract from their opinions.

169. Mr Brassington submitted that the expert evidence should be excluded. He told the Tribunal that the first consideration in assessing expert evidence is whether there are issues on which the Tribunal can be assisted by expertise. In this case, each paragraph of the Allegation, save 3 and 6, were predicated upon expert opinion. Therefore, expert evidence was required and, indeed, was the only evidence in this case.

170. Mr Brassington stated that the second consideration was whether the relevant individual has the necessary expertise. He submitted that Dr K could not be regarded as possessing the necessary expertise to entitle him to provide opinion evidence.

171. Mr Brassington submitted that the third consideration was whether the expert was aware of and had complied with his duties as an expert. In this case, he submitted Dr K could not be regarded as having complied with his duties to the Tribunal, and accordingly his evidence could not be relied upon.

172. Mr Brassington submitted that in the alternative, the opinion evidence in this case was of such tenuous character that no properly directed tribunal, taking that tenuous evidence at its highest could find the allegations proved. In addition, in respect of allegations 4(b) and 5(b)-5(e) there was simply a complete absence of evidence.

173. Mr Brassington then set out the ways in which, he submitted, Dr K had demonstrated a lack of competence and expertise:

- a. He had provided no cogent criticism of the evidence for the treatment of subthreshold bipolar disorder;
- b. He had criticised the giving of Levothyroxine to a patient who was euthyroid without addressing the literature provided by Dr Zamar that it is a safe and

- effective treatment for patients with Bipolar Disorder ('BPD') because of the different way that they respond to high doses of Levothyroxine;
- c. His opinion was not evidence based, and he agreed that rather than consider the science behind the treatment he would just say no to it;
  - d. When challenged on the *Bipolar Minds Matter* report that this report was a plea to guard against complacency and that BPD was grievously under diagnosed and the subject of delayed diagnosis, Dr K dismissed this paper as in fact an equal call to stop "*over diagnosis in BPD.*", displaying a fundamental lack of understanding;
  - e. When challenged about the suggestion that changes to Quetiapine and Alprazolam were not fast, he obfuscated and kept repeating as a mantra that the amounts of Quetiapine prescribed by Dr Zamar were "*not the dosages one would be prescribing to a child*" despite it being repeatedly pointed out to him that, by reference to the Children's British National Formulary ('BNFC'), the amounts were neither excessive nor changed quickly. He just ignored the evidence. This was a closed mind which also demonstrated starkly a failure to comply with the duties of an expert.
  - f. He had suggested that "*most*" child psychiatrists would avoid polypharmacy, failing to evidence any basis for this opinion, (as an aside he did not say "*no reasonable child psychiatrists*"). His report simply repeated this "*unevidenced mantra*". When challenged that polypharmacy is not per se inappropriate, and that appropriate polypharmacy is ok, he said that he had not heard of appropriate polypharmacy then upon receipt of Dr Zamar's exhibit, the Specialist Pharmacy Service paper on '*Understanding polypharmacy, overprescribing and deprescribing*', simply changed his evidence and suggested he had been talking about "*co-pharmacy*" and that the exhibit, in his judgment introduced more confusion rather than providing clarity. He had plainly not read it, despite having received the same before giving evidence.

174. Mr Brassington submitted that Dr K failed to comply with his duties as an expert in the following areas:

- a. He failed to identify material which mitigated against critical judgment of Dr Zamar;
- b. His failure to refer to appropriate and contemporaneous guidance or research data;
- c. His failure to indicate that he lacked the relevant expertise to opine on rTMS treatment, but offered such an opinion, and then maintained that opinion unaltered for 3 years;

- d. He only conceded a lack of expertise after he had adopted his report as his evidence in chief, and not explained he lacked expertise until cross examined on the same;
- e. No psychiatrist who was qualified to give an opinion on rTMS would have suggested that because of one study in which 3,000 pulses per session at a frequency of 10Hz were used for the treatment of unipolar major depressive disorder, the frequency of rTMS should not exceed 10Hz;
- f. No psychiatrist who was qualified to give an opinion would have referred to a frequency as “a dose”;
- g. Any psychiatrist who was qualified to give an opinion on rTMS would have been aware of the study cited by Dr M;
- h. Any psychiatrist who was qualified to give an opinion on rTMS would have been aware of the NICE guidance that rTMS is safe at 1Hz and 20Hz;
- i. All of this betrayed a fundamental and basic lack of understanding and his willingness to offer unsupported opinions outside his expertise should be a matter of great concern and disqualified him as an expert aware of his duties;
- j. He misled the Tribunal on the basis upon which he withdrew his criticisms in particular of allegation 5(e), stating it was following receipt that day of the witness statement of Dr M and in particular the paper he had “attached” as exhibit CK / 2, the paper by *Croarkin* regarding safety and efficacy of rTMS at 1hz / 20Hz; alternatively
- k. He misled the Tribunal when repeatedly asked if he had read the exhibits to Dr Zamar’s witness statement. Both cannot be true as CK / 2 was also one of Dr Zamar’s exhibits and he had been in receipt of that report for several weeks and indicated in that he had no reason to alter his opinion as a consequence of anything he had read. That was misleading and / or an abject failure in his expert duties;
- l. This Tribunal could not and should not rely upon the opinion evidence of an expert who had misled them on an important issue and who had failed to read the evidence of Dr Zamar.

175. Mr Brassington then moved on to the specific paragraphs of the Allegation that had been highlighted.

176. In relation to allegations 1 and 2, owing to the unreliability of Dr J’s expert evidence, the GMC conceded there was no case to answer. Accordingly, Mr Brassington did not address these.

177. Mr Brassington set out the following reasons for no case to answer in relation to the remaining allegations:

#### Paragraph 4

On 15 February 2022, you failed to adequately diagnose Patient D's condition, in that you did not consider the:

- a. complexity of Patient D's case;
  - i. When put to Dr K that Dr Zamar had considered the complexity of the case, his reply was "*I hope so*"; indicating he could not say he did not;
  - ii. The GMC had called no evidence therefore to prove he did not consider the complexity.
- b. context of Patient D's case.
  - i. There was no evidence on what is suggested was relevant context for Dr Zamar to have considered;
  - ii. The GMC opening referred to "*complexity*". There was no reference to "*context*" beyond a simple restatement of the allegation;
  - iii. Dr K's report regarding "*context*" provided no understanding of what the "*context*" Dr Zamar failed to consider was. There is no evidence to describe what "*context*" was left unconsidered.

#### Paragraph 5

Between 25 February and 17 May 2022, you prescribed Patient D the medication as set out in Schedule 1, and you:

- a. acted outside of your competency;
  - i. This is an allegation regarding prescribing;
  - ii. There are no NICE guidelines for the treatment of patients suffering from subthreshold BPD;
  - iii. There is no separate section of the relevant Maudlsey Prescribing Guidelines dealing with treatment for 16 year olds with subthreshold BPD;
  - iv. Accordingly, Dr Zamar who is plainly competent to prescribe treatment to patients with subthreshold BPD, did precisely that;
  - v. There was nothing in the GMC opening which established why Dr Zamar is said to have acted out with his competency;

- vi. There was nothing in the report of Dr K indicating why it is out with his competency;
- vii. The allegation was unevicenced.
- b. disregarded the opinion of a Child and Adolescent Psychiatrist;
  - i. There is no evidence at all regarding what or whose opinion was disregarded;
  - ii. The GMC opening was silent on the issue;
  - iii. The report of Dr K was silent on the issue;
  - iv. No opinion was offered by any Child and Adolescent Psychiatrist;
  - v. The allegation was unevicenced.
- c. prescribed high dose Levothyroxine, which was contraindicated for Patient D, a child, who had normal thyroid function;
  - i. There was no evidence that Levothyroxine is contraindicated in a patient with normal thyroid function;
  - ii. Dr K was unable to point to any error in Appendix 6 of Dr Zamar’s statement indicating the safety of Levothyroxine.
- d. simultaneously prescribed and/or made fast changes to Patients D’s Alprazolam and Quetiapine dosages;
  - i. There is no evidence that simultaneous prescribing of Alprazolam and Quetiapine is inappropriate;
  - ii. Dr K agreed they were both used very conservatively;
  - iii. Dr K in his report and in his evidence repeated that *“most child and adolescent psychiatrists would avoid Polypharmacy.”* That was insufficient evidence as he had not said that *“no reasonable psychiatrist would have simultaneously prescribed”* the two medications;
  - iv. The evidence is therefore that some clinicians would simultaneously prescribe. That was insufficient to raise a prima facie case;
  - v. In respect of the second part; it required as drafted, to be both fast changes to Alprazolam *and* Quetiapine;
  - vi. The BNFC indicates that the prescription of Quetiapine was not only conservative but also entirely appropriate;
  - vii. There was no evidence that the changes were fast;
  - viii. No evidence the changes to Alprazolam were fast;
  - ix. There was no prima facie case.

On behalf of the GMC

178. On behalf of the GMC, Ms Jade Bucklow, Counsel, agreed with Mr Brassington on behalf of Dr Zamar as to the test to be applied in *R v Galbraith*. Ms Bucklow drew the Tribunal's attention to the case of *Metropolitan Police Commissioner, R (on the application of) v Police Misconduct Panel* [2025] EWHC 14G2 (Admin). She submitted that, unlike the Criminal Courts, the Tribunal is applying the civil standard of proof. Further, the Tribunal must not *'fall into the "trap" of bringing forward the evaluative function which it would have at the end of all the evidence in the case'*

179. Ms Bucklow submitted that the task for the Tribunal *"is to decide whether the charge could, not whether it would, be made out"* (Nicol J, para 15 *R (Husband) v General Dental Council* [2019] EWHC 2210 (Admin)). The Tribunal was not being asked at this stage whether they accepted or preferred the opinion of the GMC's experts in respect of both patients. As per Nicol J, para 48 *R (Husband) v General Dental Council*, *"At this stage, the [panel] was not asking itself whether it did believe the two witnesses, but whether the evidence was sufficient, taken together with [the other] evidence, to support the charges."*

180. Ms Bucklow then set out the chronology of Dr K's opinion relating to Patient D. Dr K provided his expert report in respect of Patient D on 2 December 2022, This predated Dr Zamar's rule 7 response to the Case Examiners on 25 October 2025. Dr K confirmed his opinion remained the same, in his supplemental email dated 6 May 2025. Dr Zamar's defence statement (appendices and exhibits) is dated 3 September 2025, it was provided to Dr K in advance of his evidence. Dr K only had the statement of Dr M on the morning of the hearing.

181. Ms Bucklow submitted that issues of credibility or reliability of the expert, and whether the evidence is accepted or preferred, when applying *Galbraith* properly, are matters for the Tribunal; they are an evaluative decision at the end of the case.

182. Ms Bucklow submitted that Dr Zamar, in his statement and appendices and exhibits, had provided a significant number of journal papers and articles in response to the allegations in respect of Patient D. Responding to the suggestion that Dr K had not engaged in the material provided to him, and all the learning, that could contradict his opinion, Ms Bucklow submitted that the Tribunal and the experts were not here to resolve academic debate. At this stage the fact that Dr K did not agree with all the material put before him and did not accept that it changes his opinion, was not a basis to conclude the expert did not have expertise or had failed in his duty. Dr K did not have to accept journal papers, nor was he required to rebut them with another journal paper.

183. Ms Bucklow urged the Tribunal to express caution in attaching significant weight to journal articles when assessing the strength of Dr K's evidence and whether there was sufficient evidence to support the charges at this stage. Journal papers had been heavily relied upon in challenging the expert, his credibility and his expertise; the Tribunal needs to exercise caution if relying on journal papers to assess whether a witness is credible, has the right expertise and has properly exercised his duty.

184. Ms Bucklow told the Tribunal that Dr Zamar had not provided an exhaustive or complete representation of the research or range of academic opinion available. He had provided a select sample, presumably because he felt they were relevant or supported his case. Ms Bucklow submitted that not all medical journals are the same, the impact factor of a journal is an important measure of a journal's quality. It was important to consider whether they are peer reviewed, by whom, and whether the authors have a conflict of interest declared. Many of the papers provided were not directly relevant to the specific allegations in respect of Patient D, or to children or adolescents at all. Some of the papers provided by Dr Zamar dated back 15 – 20 years. Additionally, they did not state what is current acceptable practise.

185. Ms Bucklow submitted that the evidence of Dr K in his expert report was confined to the standard of Dr Zamar's care of Patient D, based on accepted clinical practice and his expertise and experience as a doctor who specialises in child and adolescent psychiatry. Much of the challenge to Dr K's reliability and credibility during his cross examination was the fact that there was a journal article that was said to be in contradiction of his opinion and he was accused of not taking it into account. The presence or support of a theory, mode of assessment, or treatment regimen in a journal paper was not evidence of acceptable and current clinical practice in child and adolescent psychiatry. Nor did it render Dr K's opinion about what is acceptable clinical practice, weak or lacking credibility.

186. Ms Bucklow submitted that Dr K was not challenged with defence expert opinion or any evidence from a child and adolescent psychiatrist. It was difficult to see how any tribunal could find his evidence had been undermined to a degree that they must stop the case or that he had been discredited in his expertise to the extent that the case must be stopped.

187. Ms Bucklow told the Tribunal that Dr K is the only person with the expertise to advise on child and adolescent psychiatry to attend this hearing. When challenging the evidence of Dr K, the defence had not sought to rely on any evidence from an expert in child and adolescent psychiatry or even a doctor qualified in child and adolescent psychiatry. They

relied on Dr Zamar's own opinion as an adult psychiatrist, and the articles and extracts of guidance and webpage screenshots.

188. Ms Bucklow submitted that part of what has been perceived as representing a lack of expertise on behalf of Dr K was, in fact, a lack of relevance of the document or section of guidance he was being asked to consider. An example of this was the *Maudsley Prescribing Guidelines* 15<sup>th</sup> edition. A lot of emphasis was placed on these guidelines and that they represent the gold standard in psychiatric prescribing, which they do. However, whilst the *Maudsley Guidelines* contain a separate chapter on prescribing in children and adolescents, and a section specifically on prescribing for BPD in children and adolescents, Dr K was cross examined on one page which relates to rapid cycling bipolar in adults from an edition that post-dated Patient D's care by three years. At the time Dr K rightly questioned the relevance of this edition of the guidance to Patient D.

189. Ms Bucklow submitted that this again arose from the very issue at the heart of the allegations in respect of Patient D. Dr Zamar treated Patient D as an adult, the evidence he sought to rely on to undermine the expertise of Dr K related to adults. Dr K's opinion remained unchallenged by somebody with the appropriate experience and speciality registration.

190. Ms Bucklow referred to Mr Brassington's submission that Dr K was not qualified to give an opinion on rTMS and acted outside of his duty. Ms Bucklow submitted that Dr K had rightfully stepped back when he felt it was outside his remit and appropriately made concessions after considering the evidence of Dr Zamar, an example of him acting within his duties. His change in opinion was due to receipt that day of a defence witness statement; nothing about that was incorrect.

191. Moving on to the specific paragraphs of the Allegation, Ms Bucklow submitted that the GMC rely on the expert opinion of Dr K and the medical records of Patient D, prior to and during her care with Dr Zamar and maintain that the evidence remains sufficient to support the charges.

192. Ms Bucklow submitted that Dr Zamar is not on the Specialist Register for Child and Adolescent Psychiatry, which requires a specific training pathway different to that of general adult psychiatrist. The evidence of Dr K was that in order to practise as a Consultant in child and adolescent psychiatry you have to have entered the Specialist Register as such. This requires completing and passing three years of higher speciality training, undertaking

placements, and the assessment of skills through work placed assessments. The requirements set out by Dr K had not been challenged.

193. Ms Bucklow submitted that it was not disputed that Dr Zamar is not a child psychiatrist and is not trained as one. The defence appeared to rebut the allegation that Dr Zamar acted outside of his competence on the basis Patient D was 16 years old, and at 16 years old Patient D can be treated by an adult psychiatrist. It relied upon a screen shot of an NHS page about moving to adult NHS services, usually around the age of 18, but can happen between 16 -25. This was relied upon to suggest to Dr K that at 16 it was acceptable to move to an adult psychiatrist. The remainder of the document was not referred to, but supported the evidence of Dr K. It did not suggest that following their 16<sup>th</sup> birthday a child is then an adult for the purposes of psychiatric care. Rather, it describes a lengthy process of transition, and assessment as to whether that is appropriate. Patient D was known to Child and Adolescent Mental Health Services ('CAMHS') and she was being treated as an adolescent by a colleague of Dr Zamar, at the time Dr Zamar took over her care. Whether that was appropriate was far more complex than simply turning 16. When this document is read properly it is consistent with the evidence given by Dr K, and this charge remained capable of proof. The Tribunal's assessment of whether Dr Zamar was acting outside of his competence, was an evaluation to be made at the end of the case.

194. Referring to allegations 4(a), 4(b) and 5(a), Ms Bucklow submitted there was some overlap in the evidence. They relied on the information that was provided by Dr E to Dr Zamar before he consulted and diagnosed Patient D. The first thing to consider was whether there was any evidence that a child psychiatrist flagged concerns about Patient D. Plainly this happened and the documentary evidence was in the form of an email exchange between Dr Zamar and Dr E. The emails from Dr E also set out the complexity and context of Patient D's case. Ms Bucklow submitted that although the Defence suggestion was that there was no evidence of what context was, there was. Dr K gave evidence that the context were the biopsychosocial factors.

195. Ms Bucklow submitted there was plainly sufficient evidence for the Tribunal to find that the concerns about Patient D's case and its complexity did exist and were known to Dr Zamar. What the Tribunal need to consider at the end of the case is whether Dr Zamar failed to take this into consideration when he took over the care of Patient D. This was a question for the end of the case on proper evaluation of all of the evidence. All the Tribunal was concerned with now was whether the charge could be made out on the evidence it had heard.

196. Ms Bucklow submitted that the charges could be made out. The Tribunal had not only the opinion of Dr K on this issue that but also correspondence to and from Dr Zamar. The Tribunal could read it and consider whether there was evidence within the correspondence that he considered or acted on the concerns or whether he dismissed them entirely. The Tribunal may find that the correspondence on one reading, reads entirely dismissive of the concerns raised, and the Tribunal may also consider that Dr E's final response to Dr Zamar demonstrated this.

197. Ms Bucklow submitted that the Tribunal also knew what Dr Zamar did when Patient D came into his care. One of the concerns about Patient D's case was her mother, who had been highlighted as a concern and as being willing to pay for her daughter to be "fixed". She had also been highlighted as possibly minimising the abuse of Patient D by XXX and was emailing Dr Zamar pushing for this treatment before he had even seen Patient D, yet he proceeded to consult Patient D with her mother present. This was also evidence that the Tribunal could take into account, when considering whether Dr Zamar did or did not take into the account the concerns that were flagged to him about Patient D and her mother.

198. Ms Bucklow, in summary, submitted that there was sufficient evidence to render the allegations capable of proof. Dr K's evidence had not been undermined to an extent that the Tribunal could not rely on it and there was other evidence it could consider when it came to determining whether the Tribunal preferred his evidence or not.

199. Ms Bucklow then addressed paragraphs 5(c) and 5(d) of the Allegation. These allegations concerned the prescribing to Patient D. Ms Bucklow submitted that in relation to the prescribing of Levothyroxine, Dr K's opinion was that this should not have been prescribed to Patient D, who was a child with normal thyroid function. There was no evidence from another child psychiatrist to contradict the opinion of Dr K in this regard. The evidence relied upon to challenge Dr K in the appropriateness of prescribing Levothyroxine related to adults.

200. Ms Bucklow submitted that Dr K was cross-examined about the presence of Levothyroxine in the *Maudlsey Prescribing Guidelines* and the fact that Dr Zamar's protocol was a reference in it. This was not the relevant part of the guidelines as it related to adults; there is an entirely different section which deals with the prescribing for children / adolescents with BPD. Dr K's opinion on Levothyroxine was supported by other evidence. In any event the dose of Levothyroxine given to Patient D exceeded the dose set out in the *Maudsley* guidelines for adults.

201. Ms Bucklow reminded the Tribunal that Dr K was also cross-examined on the simultaneous prescribing of Quetiapine and Alprazolam, and the increases in their doses. He maintained his criticism of polypharmacy in children, and the need to go slow and stay slow. He did accept that Quetiapine and Alprazolam represent copharmacy, and it was accepted that the allegation related to the prescribing of two drugs simultaneously, but should appropriately be considered in the context of the other prescribing that was happening at the same time. This was evidenced in the opinion of Dr K who, when asked about whether the type, dosage and duration of the medications and treatment prescribed / administered were appropriate, had stated:

*“Fast increase and high dose of Levothyroxine on a child with normal thyroid function (200mcg to 600mcg daily), and fast changes to Alprazolam / Quetiapine doses were inappropriate (see details in chronology above). The higher rTMS dose of 20 HZ and the sudden increase from 1Hz was inappropriate (see Expert Document Bundle p76 letter dated 23.2.2022) and should not exceed 10Hz (see Appendix H). This is out of the ordinary practice in CAMHS in the UK. Most Child Psychiatrists would start slow and go slow with medications, and avoid polypharmacy (simultaneous prescription of different classes of medications) (see Appendix I, K). This aspect of Dr Zamar’s care fell seriously below the standard expected of a reasonably competent Consultant Psychiatrist.”*

202. Ms Bucklow submitted that proper reading of this opinion showed that the criticism made of fast changes to Alprazolam and Quetiapine and the fact they were prescribed at the same time was within the context of Dr Zamar also prescribing other drugs at the same time, i.e. large doses of Levothyroxine. Dr K’s opinion of the prescribing was not unsupported. The BNF for adults and BNFC had been put before the Tribunal. Alprazolam does not appear in the BNFC at all, while it does appear in BNF for adults with a maximum dose of 3mg a day for adults. Dr Zamar prescribed and took the dose up to 6mg a day, exceeding the dose recommended in the BNF for adults. BNFC does allow use of Quetiapine but each BNF entry is not to be considered in a vacuum and it must consider what else is being prescribed at the same time.

203. Ms Bucklow submitted that the vulnerability allegation fell away if the others did, and this was not a standalone allegation. Patient D was vulnerable by virtue of her age, she was under CAMHS and was treated as a minor by Dr Zamar, accompanied by her mother to every consultation.

## Relevant Legal Principles

204. The Tribunal must bear in mind Rule 17(2)(g) and the two-tiered test as set out in *Galbraith*.

205. In applying this test, if the Tribunal considers there is no evidence that the incidents or factors are behind the allegations are made out, then the case should stop. Likewise, if the Tribunal considers that there is evidence, but looking at the evidence of the whole, it considers the evidence is so tenuous that it becomes unsatisfactory and unsafe to prove the allegations, then the Tribunal should not go any further, and should therefore dismiss the allegations. In short, if despite giving the GMC the most generous of interpretations, the case in relation to the relevant allegations is still not strong enough to convince the Tribunal of the events that support the allegations, then they should be dismissed.

206. Another formulation is whether the evidence supporting the allegations is of such a tenuous character, for example, because of some inherent weakness in it or vagueness, or because it is inconsistent with other evidence whereby the evidence is too inherently weak or vague for any sensible person to rely on it, then the case should go no further. The Tribunal must, however, not fall into the trap of bringing forward the evaluative function which it would have at the end of all the evidence in the case, namely the stage of determination of the facts. The task is to decide whether the charge could be made out, not would be made out.

### The Tribunal's Decision

207. The Tribunal found no case to answer in relation to allegations 5(e)(i) and (ii). During his evidence Dr K withdrew his support for these allegations. His expert evidence was the only evidence supporting those allegations so there was no evidence left to support them and so no case to answer. The GMC did not oppose the no case submission in relation to these allegations.

208. In relation to allegation 3 and the allegations relating to Patient C and her vulnerability, this was admitted and found proved. The Tribunal determined that this was an uncontroversial aspect to the case and the proven allegation 3 did not take the GMC any further in supporting its case in relation to allegations 1 and 2 and in proving unfitness to practice.

209. In relation to allegations 1 and 2 relating to Patient C, the Tribunal noted that the GMC did not oppose the submission of no case to answer. The GMC case in relation to allegations 1 and 2 rested substantially on the evidence of Dr J. The Tribunal determined that

the oral and written evidence of Dr N the context of all the evidence was such that taking the GMC case at its highest no reasonable tribunal could find allegations 1 and 2 proved. The Tribunal noted the duties of an expert witness: to be independent, objective and unbiased and to consider all the material facts including evidence that supported or contradicted a matter in dispute and that supported or contradicted the expert's opinion.

210. The Tribunal observed that Dr N his oral evidence did not appear to be objective. He paid little or no heed to the research studies exhibited by Dr Zamar that appeared to contradict Dr J's evidence. While it was not the role of the Tribunal to consider the accuracy or otherwise of the research studies it did expect an expert to consider and reflect on them and give full answers as to why he disagreed with them or considered that they did not apply. Dr J came across as dismissive of the research papers Dr Zamar had exhibited. Dr J said in his evidence that he could not critically appraise every article and that he relied on his many years of clinical experience. When cross-examined on the papers, he repeatedly tried to shut the questions down. The Tribunal was left with the impression that Dr J had not properly considered or responded to those research papers and appeared unwilling to engage with them. In addition, Dr J was *"quite confident"* of his diagnosis of Patient C having an adjustment disorder with depression when, when questioned, he conceded that there was room for alternative diagnoses such as that of Dr Zamar. Dr J came across as lacking objectivity and failing to look critically at alternative diagnoses. The Tribunal, therefore, had serious concerns as to his reliability as an expert witness. It considered that the GMC by implication accepted those concerns when it did not oppose the no case submission.

211. The Tribunal determined that there was no case to answer in relation to allegations 1 and 2 and they were dismissed.

212. In relation to the allegations relating to Patient D the GMC's case relied substantially on the expert evidence of Dr K. The Tribunal first considered whether similar considerations applied to Dr K as applied to Dr N terms of Dr K's reliability and credibility as an expert witness. Mr Brassington submitted that similar considerations did apply and that Dr K's evidence could not be relied upon, should be excluded and that therefore there was no case to answer. Mr Brassington also submitted that Dr K's evidence was so tenuous that it could not be relied upon. In Dr J's case the GMC was taken to have conceded that Dr J was not a reliable or credible whereas for Dr K it did not. The Tribunal reminded itself of the duties of an expert witness as set out in paragraph 6, above.

213. The Tribunal noted that Dr K had resiled from his original expert opinion in relation to rTMS as alleged in allegation 5(e). He gave evidence that he did so after receiving the witness

statement of Dr M and the attached research paper on the morning of him giving evidence. Mr Brassington argued that that research paper had been one of the exhibits in his bundle which Dr K had already received. The Tribunal noted that Dr K, unlike Dr J, had demonstrated the ability as an expert to reconsider his opinion when appropriate.

214. The Tribunal noted the criticism of Dr K in not considering the research paper exhibited by Dr Zamar at a much earlier stage and not then confirming his change of opinion. The Tribunal disagreed with the submission that this failure wholly undermined Dr K's evidence. It considered that there was some leeway for an expert to be wrong about one aspect of his evidence but right about his other evidence. His resiling of his opinion about rTMS did not, in the Tribunal's judgement, automatically mean that the rest of his evidence had to be disregarded. The Tribunal took account of the large quantity of research material exhibited by Dr Zamar and that it was not so wholly unreasonable for an expert to miss something in that material. However, the Tribunal observed that, in contrast to Dr J, when taken to specific papers, Dr K was willing to reflect upon those papers and his opinion appropriately. The Tribunal noted that Dr K, in contrast to Dr J, exhibited research papers to support his opinion. The Tribunal also took into account that it appeared that rTMS was not a mainstream form of treatment, that there were few experts in it and that Dr K could be afforded some leeway in that context.

215. The Tribunal took into account that the only direct expert evidence in the case from a child and adolescent psychiatrist was from Dr K. The Defence criticism of Dr K was from the perspective of Dr Zamar being an adult psychiatrist. The Tribunal took into account the GMC submission that in these circumstances it was difficult to conclude that his evidence has been undermined and / or discredited to a degree that the Tribunal must find no case to answer. It took into account the GMC submission that Dr K's opinion was not challenged by an expert with the appropriate experience and speciality registration in child and adolescent psychiatry.

216. The Tribunal did not consider that it could dismiss Dr K's clinical experience out of hand and took into account that Dr K's evidence was capable of support by other evidence such as Patient D's medical records. Dr K did reference external material to support his expert evidence e.g. the NICE guidelines and did refer to the material provided by Dr Zamar. He did answer questions about the research papers that Dr Zamar exhibited and gave reasons as to why they did not change his opinion. This was not a case of an expert making assertions without consideration of that evidence. For example, Dr K said in his opinion that there were marked differences between clinical experience / 'bedside' and the results of large scale research studies. He gave mixed answers in relation to the *Bipolar Minds Matter* paper. One of his answers was that he did not take issue with its conclusions and in particular Professor

P's comments in the paper. Dr K' reservations about the paper were capable of being understood as a request to be cautious before risking an over diagnosis of bipolar and / or rushing to non-mainstream treatments. This was in contrast to Dr J who came across as wholly dismissive of it. In relation to the issue of a 16 year old being treated by an adult psychiatrist, reference was made to NHS guidelines that allowed for this. The Tribunal noted criticisms of Dr K' opinion but accepted the GMC submission that an alternative reading of those guidelines was capable of supporting his evidence.

217. The Tribunal, while noting the trenchant criticisms of Dr K's evidence, did not consider that Dr K came across as having a closed mind or that he was biased. The Tribunal considered that a tribunal could find that Dr K had taken into account the complexity of Patient D's case and the context as a whole. For example his assertion that there was a need to go slow with a patient of Patient D's age and complexity was not one that could be dismissed at this stage in the totality of the evidence including the NICE guidelines. Another example is Dr K's opinion about administering Levothyroxine to Patient D. His view that administering Levothyroxine to a child of this age did not feel right was an issue that the Tribunal considered should properly be evaluated rather than dismissed out of hand.

218. In summary the Tribunal was not of the view for the purposes of the submission of no case to answer that Dr K's evidence in the context of all the evidence was so unreliable whereby the GMC case taken at its highest could not be proved in relation to allegations 4 and 5(a) to (d). The conflict in expert evidence should be resolved at the evaluative stage when the Tribunal reached its determination as to the allegations having evaluated all of the evidence. As Nicol J said in the *Husband* case at this stage the Tribunal should not ask whether it did believe the expert evidence but whether the evidence was sufficient, taken together with the other evidence to support the allegations.

219. The Tribunal had regard to Mr Brassington's submissions that there was no evidence to support each of the allegations. In relation to allegation 4, that on 15 February 2022, Dr Zamar failed to adequately diagnose Patient D's condition, in that he did not consider the: (a) complexity of Patient D's case; and (b) context of Patient D's case, Mr Brassington submitted that when Dr K was asked if Dr Zamar had considered the complexity of Patient D's case he replied, "*I hope so*". The Tribunal did not consider this reply in the context of all the evidence to be one that fatally undermined the GMC case for allegation 4(a). That argument was more suited for the evaluative stage of fact determination. The same applied to considerations of allegation 4(b). In the Tribunal's judgement this was again a matter more suited for resolution at the evaluative stage of fact determination.

220. Similar considerations applied to allegations 5(a) to (d) that between 25 February and 17 May 2022, Dr Zamar prescribed Patient D the medication as set out in Schedule 1, and that he (a) acted outside of his competency; (b) disregarded the opinion of a child and adolescent psychiatrist; (c) prescribed high dose Levothyroxine, which was contraindicated for Patient D, a child, who had normal thyroid function; and (d) simultaneously prescribed and / or made fast changes to Patient D's Alprazolam and Quetiapine dosages. The Tribunal was satisfied taking into account the totality of the evidence that there was sufficient evidence whereby the GMC's case taken at its highest could (not would) prove the allegations. Dr K's opinion cautioning against a rush to medicate a minor was one that should be evaluated in the context of the totality of the evidence.

221. In relation to allegation 6 the Tribunal agreed with the parties that the partial admission that Patient D was vulnerable due to her mental health did not materially take the GMC case further. It was uncontroversial that Patient D was vulnerable due to her mental health. The Tribunal noted that it was not admitted that she was vulnerable by virtue of being a minor. A determination on this issue would also not take the GMC case any further.

222. The Tribunal rejected the submission of no case to answer in relation to allegations 4 and 5(a) to (d) and will now proceed to continue with the determination of the allegations.

Schedule 1 – Patient D

Date	Medication dosage	Dose
15 February 2022	rTMS	at 20Hz
25 February 2022	Alprazolam Quetiapine Levothyroxine	0.25mg 50mg 200mcg
2 March 2022	Levothyroxine	200mcg
4 March 2022	Levothyroxine Fluoxetine Alprazolam rTMS at 20Hz	250mcg 10mg 0.25 mg 20Hz
10 March 2022	Levothyroxine Alprazolam Alprazolam	300mcg 0.5 mg 1mg
15 March 2022	Fluoxetine Levothyroxine Quetiapine Quetiapine Alprazolam	4ml 350mcg 50mg 100mg 1mg
21 March 2022	Quetiapine	100mg
23 March 2022	Quetiapine Levothyroxine rTMS at 20Hz Alprazolam	100mg 400mcg 20Hz 2mg
25 March 2022	Fluoxetine Quetiapine Quetiapine Levothyroxine Alprazolam	20mg 100mg 200mg 400mcg 2mg
28 March 2022	Levothyroxine Fluoxetine Quetiapine Quetiapine Alprazolam 2mg	450mcg 20mg 100mg 200mg 2mg
31 March 2022	Quetiapine Clonazepam	100mg 2mg

Record of Determinations –  
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1 April 2022	Clonazepam Levothyroxine Fluoxetine Quetiapine Quetiapine	2mg 450mg 20mg 100mg 200mg
4 April 2022	Stopped Quetiapine Levothyroxine Alprazolam Fluoxetine	 500mcg 2mg 20mg
7 April 2022	Levothyroxine Alprazolam Quetiapine	500mcg 2mg 200mg
11 April 2022	Levothyroxine Fluoxetine Alprazolam Quetiapine	550mcg 12mg 2mg 200mg
14 April 2022	Clonazepam Fluoxetine Levothyroxine Alprazolam	2mg 8mg 600mcg 2mg
25 April 2022	Fluoxetine Levothyroxine Quetiapine Clonazepam	8mg 600mcg 200mg 2mg
28 April 2022	Fluoxetine Levothyroxine Pabrinex 2 vials	4mg 600mcg 2 vials
3 May 2022	Quetiapine	200mcg
10 May 2022	Levothyroxine rTMS	600mc
12 May 2022	Levothyroxine  Continue Prabinex injections	600mcg
18 May 2022	Levothyroxine	400mcg
20 May 2022	Levothyroxine	400mcg