PUBLIC RECORD

Dates: 26/07/2021 - 15/10/2021;
04/01/2022 – 07/01/2022;
04/04/2022 – 22/04/2022
06/06/2022 – 17/06/2022;
27/06/2022 – 30/06/2022

Medical Practitioner's name:	Dr Helen WEBBERLEY
GMC reference number:	3657058
Primary medical qualification:	MB ChB 1992 University of Birmingham

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

Summary of outcome

Suspension, 2 months.
Review hearing directed
Immediate order imposed

Tribunal:

Legally Qualified Chair	Mr Angus Macpherson
Lay Tribunal Member:	Dr Nigel Westwood
Medical Tribunal Member:	Dr Nagarajah Thevamanoharan

Tribunal Clerk:	Mr Sewa Singh Miss Keely Crabtree (9 – 13 August 2021) Ms Angela Carney (24 September 2021) Mrs Jennifer Coakley (8 April 2022)

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Ian Stern, QC, instructed by Gunnercooke LLP
GMC Representative:	Mr Simon Jackson, QC

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 - 22/04/2022

Background

1. Dr Webberley qualified in 1992 from the University of Birmingham, UK. She passed the Royal College of General Practitioners (RCGP) membership examinations in 1996. She obtained a Diploma of the Institute of Psychosexual Medicine in 2002. She undertook career grade training in sexual and reproductive health in 2006 and attained membership of the Faculty of Reproductive and Sexual Health in 2007. She attained a RCGP Certificate in Gender Variance in 2015. In 2016, Dr Webberley resigned from her GP partnership in Wales, and pursued an interest in the care of transgender patients. At the time of the events in question, Dr Webberley was providing transgender services and treatment to patients via her online website, Gender GP. Dr Webberley also practised at various times as a NHS GP and provided her services to other online healthcare providers.

2. The allegations that have led to Dr Webberley's hearing are, in summary, that:

- between March 2016 and May 2017, she failed to provide good clinical care and treatment to three transgender adolescents, namely Patients A, B and C;
- In respect of her work with an online healthcare service, namely Dr Matt Limited:
    - on 26 August 2016, she inappropriately:
        - dealt with a medication request from Patient E;
        - prescribed Doxycycline to Patient E
    - on 23 September 2016, she inappropriately prescribed an increased dose of metformin to Patient D;
    - on 10 January 2017, during an announced CQC inspection, notwithstanding that she was the Safeguarding Lead, she was unaware of or had never seen the safeguarding policy;

- on 5 March 2017, she dishonestly submitted a Work Details Form in which she failed to declare that she was sub contracted to provide medical services to Frosts Pharmacy Limited ('FPL') until May 2017;
- on 25 April 2017, she dishonestly failed to declare to FPL that she was suspended from the Medical Performers List;
- on 9 May 2017, she dishonestly submitted to the Interim Orders Tribunal of the MPT a witness statement and other documents stating that she was a member of the RCGP;
- in July 2017, she repeatedly and dishonestly frustrated the Aneurin Bevan University Health Board (ABUHB) from carrying out a review into her on-line prescribing practice, and failed to advise the ABUHB of open GMC investigations against her;
- alongside Dr SS, when acting as the principal provider of the Gender GP website, she attempted to avoid the healthcare regulatory framework of the United Kingdom;
- on 5 October 2018 at Mid Wales (Merthyr Tydfil) Magistrates' Court, she was convicted of two counts in relation to the carrying on or managing of an independent medical agency without being registered under the Care Standards Act 2000, and was fined £12,000.

3. The GMC's case concerning Patients A, B and C was occasioned as follows:

<u>Patient A</u>

4. In December 2016, Professor I, Paediatric Endocrine Consultant, who at the time was the Clinical Director of Paediatrics at the University College London Hospitals ('UCLH'), raised concerns about the care and treatment provided by Dr Webberley to Patient A. Patient A, born a female, and aged 12 years at the time, had been under a care and review arrangement organised by the NHS England Gender Identity Development Service ('GIDS') at the Tavistock and Portman NHS Foundation Trust (TFPT) in conjunction with UCLH, for the previous two years for the management of his gender dysphoria, as part of his transitioning from female to male.

5. Patient A's family had contacted Dr Webberley via one of her websites, MyWebDoctor ('MWD'). This website was described as advising on various ways of starting gender-affirmation hormone ('GAH') therapy (in this case testosterone) if it could not be accessed through the NHS. The concerns include that Dr Webberley prescribed GAH therapy to Patient A when this treatment was not considered appropriate in persons of 16 years or younger; prescribed a higher dose of testosterone than the recommended dose; did not arrange for Patient A to undergo a psychological assessment or be assessed under the management of a multi-disciplinary team (MDT) approach.

<u>Patient B</u>

6. In October 2017, the GMC was contacted by Dr G, a consultant child and adolescent psychiatrist with the Buxton Child and Adolescent Mental Health Service (CAMHS), Tier 3

service. Patient B, who was 17 years old at the time, was assigned female at birth but identified as male. Patient B was referred to Dr G by his GP in May 2017 due to concerns about his low mood and risk of self-harm. Patient B's first consultation with Dr G took place on 22 August 2017 and, at that consultation, Patient B advised Dr G that he was under the care of a transgender clinic in Leeds and that he was also receiving testosterone treatment from a GP with an interest in Gender Dysphoria (GD), based in Wales, namely Dr Webberley. Patient B told Dr G that he was taking half of a 'normal' dose per day (25mg), and that he had obtained this medication from Dr Webberley via her internet website.

7. Patient B advised Dr G that he began to go through male puberty around two months after first taking the testosterone supplements, and that his *'head and mood were all over the place'*. Concerned about the effect the testosterone might be having on Patient B's mental health, Dr G raised questions about whether the prescribing of testosterone to Patient B was in line with standard practice. Mindful of the potential psychological impact of stopping the treatment for Patient B, Dr G decided to gather further information and re-engage Patient B with appropriate services in relation to Patient B's wish to continue to receive Gonadotropin-releasing hormone agonist (GnRHa) treatment.

8. On 24 August 2017, Dr G sent a letter to Patient B's NHS GP following a consultation with Patient B, with a copy being sent to Dr Webberley and to GIDS (at their Leeds site). In that letter, Dr G set out Patient B's then presentation and the psychological problems that he was experiencing; the psychological impact of the testosterone treatment on Patient B; and explained the consultation with Patient B and the proposed management and treatment plan, which included liaising with Dr Webberley, in order to clarify Dr Webberley's assessments, monitoring and management of Patient B. With no response having been received from Dr Webberley, Dr G attended Patient B's GP practice - The Stewart Medical Centre and viewed Patient B's GP records, noting that only one piece of correspondence had been received by the GP surgery from Dr Webberley on 30 September 2016 stating that she had recently sent a shared care agreement ('SCA') to Dr J, Patient B's GP, and that she understood he was willing to issue a prescription to Patient B, though there was no SCA on Patient B's records.

9. The Tribunal noted that, in September 2016, Patient B and his mother advised Dr G that they were happy with the treatment provided by Dr Webberley and that they were reluctant to re-engage with the Leeds GIDS. In October 2017, Dr G saw Patient B with his mother and they discussed the possibility of issuing a 'bridging prescription' of testosterone to Patient B, provided Patient B and his mother re-engaged with Leeds GIDS, and with an expedited appointment with an endocrinologist, to which Patient B and his mother agreed.

<u>Patient C</u>

10. Patient C was born in March 2006 and assigned as female at birth. Patient C had been diagnosed with GD and identified as male. Dr K became Patient C's GP in September 2017 at the Sunny Meed Surgery. However, Patient C attended the surgery in June 2016, when he was 11 years old with his mother who was seeking help around GD. Patient C was seen by a

GP at the surgery who referred Patient C to GIDS. Due to the long waiting list at GIDS, Patient C's family sought treatment elsewhere and contacted Dr Webberley via her online website. On 2 March 2017, the surgery received a letter from Dr Webberley in which Dr Webberley explained that she, along with a psychologist, had seen Patient C and discussed the role of puberty blockers (sometimes referred to as hormone blockers) with Patient C and the effect this treatment could have on fertility. In her letter Dr Webberley asked the surgery if it could arrange for routine blood tests and then to prescribe and administer GnRHa under her supervision and via a SCA.

11. Patient C's GP at the time was concerned about initiating the treatment because it was beyond the specialism of the surgery, and about entering into a SCA with a private specialist/provider. The surgery sought advice from the local Clinical Commissioning Group (CCG) who referred the surgery to the GIDS. Around this time, Patient C attended GIDS for a first appointment but no medication was prescribed to Patient C. At that time, he was in receipt of a prescription for puberty blockers issued by Dr Webberley.

12. In September 2017, Patient C's mother approached his GP to discuss the administration of the puberty blockers as she was finding it difficult to administer them herself. The surgery sought advice from Professor F at the UCLH. Professor F raised concern that Patient C had been prescribed puberty blockers without the appropriate assessments, including any psychological assessments. Further, Professor F was also concerned that Dr Webberley's clinical practice was restricted by the GMC, and that he had reported his concerns to the GMC.

13. The GMC's case in respect of the other matters concerned the following:

<u>Dr Matt Limited</u>

14. On 10 January 2017, the Care Quality Commission (CQC) carried out an announced inspection of Dr Matt Limited, an online prescribing company, for which Dr Webberley was identified as the Registered Manager. The reason for the inspection was that the CQC had identified digital services providers as being at higher risk of failing to comply with CQC requirements than other providers registered with the CQC. Dr Matt Limited was one of the first digital services providers inspected by the CQC because of the types of medication it prescribed. Dr Webberley was not present during the inspection, but she was available via Skype for the majority of the day. Other staff members were at the premises of DMC Medical (the company that owned Dr Matt Limited).

15. The CQC audited 25 patient records and identified concerns about adequate record keeping. Concerns about prescribing and safeguarding were also identified in respect of two patients (Patient D and Patient E) where, it is alleged, Dr Webberley inappropriately prescribed a high dosage of metformin on 23 September 2016 (in the case of Patient D) and undertook an inadequate assessment, care and treatment (in the case of Patient E). Concern was also raised about Dr Webberley's lack of awareness of the company's safeguarding policy.

16. On 11 January 2017, the CQC held an urgent management review meeting at which it was determined that the registration of Dr Matt Limited, the provider, should be suspended. Dr Webberley was informed of this decision. The CQC raised their concerns with the GMC on 17 January 2017, and also informed Healthcare Inspectorate Wales ('HIW').

The Royal College of General Practitioners

17. Dr Webberley passed the RCGP membership examination in November 1996. Passing the RCGP examination entitled her to apply for membership of the RCGP. Dr Webberley did not apply to become a member of the RCGP and was therefore not entitled to sign her correspondence, publications etc using the post-nominal 'MRCGP'. Dr Webberley used MRCGP in some communications with the Interim Orders Tribunal of the MPT. It was alleged that she dishonestly did so.

Work Details Form (WDF)

18. As part of its investigation, the GMC asked Dr Webberley to complete and return a WDF, part of which requires the practitioner to provide details of past and present employment. Dr Webberley completed her WDF dated 5 March 2017. The GMC learnt that Dr Webberley had approached Mr R, Managing Director of FPL, an independent group of pharmacies in the Oxford area, in 2014 to provide online prescribing services, and that Dr Webberley was employed as a provider of 'remote' online consultation services. It is alleged that Dr Webberley did not provide this information in her WDF and she failed to declare that she was sub-contracted to provide medical services to FPL until 24 May 2017. It is alleged that her conduct in failing to disclose this information was dishonest.

Suspension from the MPL

19. It is alleged that Dr Webberley dishonestly failed to notify FPL that she had been suspended from the Medical Performers List in Wales on 25 April 2017.

Aneurin Bevan University Health Board (ABUHB)

20. Dr Webberley was required to be on the MPL, maintained by ABUHB, for any NHS GP practice she undertook in Wales. ABUHB became aware of the CQC's concerns and initiated a review of Dr Webberley's online services and her practice in July 2017. It was alleged that Dr Webberley repeatedly frustrated the review and failed to advise the ABUHB of open GMC investigations concerning her.

Health Inspectorate Wales (HIW) and Conviction

21. In 2017, HIW, the inspectorate and regulator of healthcare in Wales, became aware of the Gender GP and MWD websites and Dr Webberley's activities in respect of these. An initial investigation concluded that the healthcare services provided by Dr Webberley via these websites was not registered with HIW in accordance with statutory requirements. Criminal proceedings were instigated against Dr Webberley.

22. In September 2017, the GMC received information from HIW that it had been made aware of ABUHB's concerns around the Gender GP and MWD websites in 2016. HIW contended that it was an offence under section 11 of the Care Standards Act 2000, 'for a person to carry on or manage an establishment or agency without being registered under that Act'.

23. On 3 December 2018 Dr Webberley was convicted under the Care Standards Act 2000 for carrying on/managing an independent medical agency and, as director, consented to the company carrying on or managing an independent medical agency, namely Online GP Services, without it being registered. Online GP Services was the company through which Dr Webberley ran her gender GP and MWD websites. Dr Webberley was fined £12,000.

The Outcome of Applications Made during the Facts Stage

24. The Tribunal granted an application made by Mr Ian Stern QC, Counsel for Dr Webberley, to admit a number of documents into evidence, pursuant to Rule 34 of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'). The Tribunal's determination is set out in Annex A.

25. The Tribunal granted an application made by Mr Simon Jackson QC, Counsel for the GMC, to amend paragraphs 1(b), 3(b) and 5(a) of the Allegation, pursuant to Rule 17(6) of the Rules. The Tribunal's determination is set out in Annex B.

26. The Tribunal of its own volition invited parties to make submissions in relation to whether further documentation should be admitted into evidence, pursuant to Rule 34 of the Rules. The Tribunal's determination is set out in Annex C.

27. The Tribunal refused an application made by Mr Jackson to admit extracts of Dr Webberley's response to the Rule 7 letter into evidence, pursuant to Rule 34 of the Rules. The Tribunal's determination is set out in Annex D.

28. The Tribunal granted an application made by Mr Stern as to no case to answer in respect a number of paragraphs of the Allegation, pursuant to Rule 17(2)(g) of the Rules. The Tribunal's determination is set out in Annex E.

29. The Tribunal granted an application made by Mr Jackson to admit into evidence a bundle of documents which it had produced, pursuant to Rule 34 of the Rules, following the disclosure of further evidence from the defence. The Tribunal's determination is set out in Annex F.

30. The Tribunal, of its own motion, determined to amend paragraph 9 of the Allegation, so that the stem of the paragraph reads:

> 'On 10 January 2017, during an announced CQC inspection of Dr Matt Limited, you were the Safeguarding Lead, and you:'

The reason for the amendment was that the GMC mistakenly described the CQC inspection as an unannounced inspection when in fact it was an announced inspection. Advance notice of the Tribunal's intention so to do was given to the parties. They did not oppose it. Accordingly, the Tribunal determined not to set out its reasoning in an annex.

The Allegation and the Doctor's Response

31. The Allegation made against Dr Webberley is as follows:

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

Patient A

1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

a. obtain an adequate medical history for Patient A, in that you failed to elicit information about:

i. Patient A's physical or psychosocial childhood;
To be determined

ii. adolescent development;
To be determined

iii. gender identification and development;
To be determined

iv. any adaptions made to address gender incongruence;
To be determined

v. mental health;
To be determined

vi. self-harm or suicidal ideation and associated risk factors;
To be determined

b. arrange for Patient A to be adequately examined prior to prescribing testosterone treatment, including:
Amended under Rule 17(6)

i. a physical examination to determine:

1. blood pressure; **To be determined**

2. weight development; **To be determined**

3. final height assessment; **To be determined**

4. bone health; **To be determined**

5. an assessment to ensure a synchronised pubertal development with peers; **To be determined**

ii. a psychological assessment to confirm a diagnosis of gender dysphoria;
To be determined

c. prescribe clinically-indicated treatment to Patient A, in that testosterone:

i. was not appropriate for use in children of Patient A's age;
To be determined

ii. was commenced without the input of an integrated multi-disciplinary team beforehand;
To be determined

d. ensure it was feasible for Patient A to receive the correct dosage of testosterone as prescribed by prescribing a metered dispenser rather than in sachet form;
To be determined

e. assess Patient A's capacity to consent to treatment;
To be determined

f. in the alternative to paragraph 1e, record any assessment of Patient A's capacity to consent;
To be determined

g. provide adequate follow-up care to Patient A after initiating testosterone treatment in that you failed to:

i. arrange assessments to evaluate Patient A's response to testosterone treatment, including:

1. psychosocial development monitoring;
To be determined

2. physical development monitoring;
To be determined

3. laboratory testing;
To be determined

h. inform Patient A's GP of the medication you were prescribing to A;
To be determined

i. seek a psychological assessment after Patient A's mental health deteriorated;
To be determined

j. adequately communicate with Patient A's other treating physicians at the Gender Identity Clinic at University College London Hospitals after you commenced testosterone treatment;
To be determined

k. maintain an adequate record of Patient A's treatment in that entries in records were:

i. infrequent;
To be determined

ii. made by administrative staff;
To be determined

iii. unclear as to who had made them;
To be determined

iv. made using email print-offs rather than an electronic record system;
To be determined

l. engage in and / or with an adequately trained and specialist multidisciplinary or interdisciplinary team, in that you did not seek input before and during treatment from:

i. a paediatric endocrinologist;
To be determined

ii. a mental health practitioner;
To be determined

iii. LGBT and trans organisations which Patient A was attending.
To be determined

2. In treating Patient A as set out at paragraph 1 above, you:

a. failed to adhere to the following professional guidelines:

i. Endocrine Society Professional Guidelines (2009);
To be determined

ii. World Professional Association for Transgender Health Standards of Care (7th Edition);
To be determined

b. knew or ought to have known you were acting outwith the limits of your competence as a General Practitioner with a special interest in gender dysphoria.
To be determined

Patient B

3. Following an initial consultation with Patient B on or about ~~11~~ 10 August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

a. obtain an adequate medical history for Patient B, in that you failed to elicit information about:

i. general development history;
To be determined

ii. age of onset of puberty and subsequent pubertal development;
To be determined

iii. physical history;
To be determined

iv. mental health history;
To be determined

v. medication use;
To be determined

vi. smoking, alcohol and substance use;
To be determined

vii. forensic history;
To be determined

b. arrange for Patient B to be **adequately** examined prior to prescribing testosterone treatment, including:
Amended under Rule 17(6)

i. a physical examination to determine:

1. blood pressure; **To be determined**

2. weight development; **To be determined**

ii. a psychological assessment to:

1. confirm a diagnosis of gender dysphoria;
To be determined

2. consider alternative diagnoses;
To be determined

3. determine Patient B's mental health needs;
To be determined

c. liaise with those who had previously provided care with regard to Patient B's mental health needs, including:

i. the Tavistock and Portman NHS Foundation Trust Gender Identity Development clinic ('the Tavistock');
To be determined

ii. Patient B's private therapist;
To be determined

iii. the Child and Adolescent Mental Health Services team;
To be determined

d. conduct an adequate assessment of Patient B prior to testosterone treatment, including eliciting details of:

i. height; **To be determined**

ii. weight; **To be determined**

iii. blood pressure; **To be determined**

iv. Tanner staging of Patient B's pubertal development, including stages of:

1. pubic hair growth; **To be determined**

2. breast development; **To be determined**

e. obtain informed consent in that you failed to ascertain:

i. how Patient B had reached the decision to agree to his treatment plan; **To be determined**

ii. whether Patient B understood the long term risks of the treatment proposed; **To be determined**

f. adequately assess Patient B's capacity to consent to treatment;
To be determined

g. in the alternative to Paragraph 3f, record any assessment of Patient B's capacity to consent;
To be determined

h. provide adequate follow-up care to Patient B after initiating treatment in that you failed to arrange review consultations;
To be determined

i. provide the correct change to Patient B's prescription when he reported continued menstruation in that you:

i. failed to prescribe a step-up dosage of testosterone;
To be determined

ii. inappropriately prescribed Gonadotropin-releasing Hormones ~~('GnHRa')~~ <u>(GnRHa)</u>; **Amended under Rule 17(6)**
To be determined

j. engage in and / or with an adequately trained and specialist multidisciplinary and interdisciplinary team, in that you did not seek input before and during treatment from a:

i. paediatric endocrinologist; **To be determined**

ii. mental health practitioner. **To be determined**

4. In treating Patient B as set out at paragraph 3 above, you:

a. failed to adhere to the following professional guidelines:

i. Endocrine Society Professional Guidelines (2009);
To be determined

ii. World Professional Association for Transgender Health Standards of Care (7th Edition);
To be determined

b. knew or ought to have known you were acting outwith the limits of your competence as a General Practitioner with a special interest in gender dysphoria.
To be determined

Patient C

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

a. did not arrange for Patient C to be **adequately** examined prior to prescribing ~~testosterone and GnHRA~~ GnRHa treatment, including:
Amended under Rule 17(6)

i. a physical examination to determine:

1. bone health; **To be determined**

2. height; **To be determined**

3. weight; **To be determined**

4. blood pressure; **To be determined**

5. Tanner staging of Patient C's pubertal development, including stages of:

i. pubic hair growth; **To be determined**

ii. breast development; **To be determined**

ii. full psychological pre-diagnostic input to:

1. clarify diagnoses; **To be determined**

2. explore additional factors, including Attention Deficit Hyperactivity Disorder; **To be determined**

b. did not record the details of any assessment as set out at paragraph 5a above;
To be determined

c. prescribed ~~GnRHA~~ GnRHa to Patient C without:
Amended under Rule 17(6)

i. the adequate training, qualifications or experience in the field of paediatric endocrinology;
To be determined

ii. working as part of a specialist multidisciplinary team in gender care for children and adolescents;
To be determined

d. advised Patient C as to the risks of ~~GnRHA~~ GnRHa before commencing treatment without: **Amended under Rule 17(6)**

i. the adequate training, qualifications or experience in the field of paediatric endocrinology;
To be determined

ii. working as part of a specialist multidisciplinary team in gender care for children and adolescents;
To be determined

iii. discussing the risks to Patient C's fertility;
To be determined

e. did not assess Patient C's capacity to consent to treatment;
To be determined

f. in the alternative to Paragraph 5e, did not record any assessment of Patient C's capacity to consent;
To be determined

g. did not record Patient C's reasoning ability and competence with regards to his treatment;
To be determined

h. did not provide adequate follow-up care to Patient C after initiating ~~GnRHA~~ GnRHa treatment in that you:
Amended under Rule 17(6)

i. failed to monitor Patient C's physical development;
To be determined

ii. did not review Patient C's treatment plan with a multi-disciplinary team when Patient C started his menstruation cycle, including considering the prescribing of progestins;
To be determined

i. did not maintain an adequate record of Patient C's care in that entries in records were:

i. infrequent; **To be determined**

ii. made by administrative staff; **To be determined**

iii. unclear as to who had made them; **To be determined**

iv. made using email print-offs rather than an electronic record system; **To be determined**

j. did not engage in and/or or with an adequately trained and specialist multidisciplinary and interdisciplinary team, in that you did not seek:

i. any input before and during treatment from a paediatric endocrinologist;
To be determined

ii. psychological input following an initial assessment;
To be determined

iii. input from services already engaged in Patient C's care at the Tavistock.
To be determined

6. In treating Patient C as set out at paragraph 5 above, you:

a. failed to adhere to the following professional guidelines:

i. Endocrine Society Professional Guidelines (2009);
To be determined

ii. World Professional Association for Transgender Health Standards of Care (7th Edition);
To be determined

b. knew or ought to have known you were acting outwith the limits of your competence as a General Practitioner with a special interest in gender dysphoria.
To be determined

CQC – Dr Matt Limited

7. On the dates set out in Schedule 1, you inappropriately prescribed an increased dose to Patient D through a pharmacy website without any evidence that the change in dose was correct.
To be determined

8. On 26 August 2016, you dealt with Patient E's medication request made through a pharmacy website and you:

a. failed to:

~~i. adequately assess Patient E in that you did not seek further details of~~:

~~1. their symptoms~~;
Withdrawn following a successful Rule 17(2)(g) application

~~2. why they thought they had a STI~~;
Withdrawn following a successful Rule 17(2)(g) application

ii. refer Patient E to a Genito Urinary Medicine clinic for further investigations and/or tests;
To be determined

iii. provide follow up advice in that you did not advise Patient E to attend at a GUM clinic in the event that they were suffering from a STI;
To be determined

~~iv. record your:~~

~~1. assessment of Patient E as set out at paragraph 8ai above;~~ **Withdrawn following a successful Rule 17(2)(g) application**

~~2. referral of Patient E to a GUM as set out at paragraph 8aii above;~~ **Withdrawn following a successful Rule 17(2)(g) application**

~~3. follow up advice to Patient E as set out at paragraph 8aiii above;~~ **Withdrawn following a successful Rule 17(2)(g) application**

b. prescribed 'Doxycycline 100mg 2 daily for 2 weeks' to Patient E which was not clinically indicated because you did not:

~~i. adequately assess Patient E as set out at paragraph 8ai above;~~
Withdrawn following a successful Rule 17(2)(g) application

ii. refer Patient E for further investigations as set out at paragraph 8aii above.
To be determined

9. On 10 January 2017, during an ~~un~~announced CQC inspection of Dr Matt Limited, you were the Safeguarding Lead and you: **Amended by the Tribunal**

a. were unaware of the safeguarding policy;
To be determined

b. had never seen a copy of the safeguarding policy.
To be determined

Royal College of General Practitioners ("RCGP")

10. On 9 May 2017 you submitted to the Interim Orders Tribunal ('the IOT') a:

a. signed witness statement in which you stated that you had been a member of the RCGP since 1996; **Admitted and found proved**

b. copy of your Curriculum Vitae which stated that you had been a member of the RCGP since 1996.
To be determined

11. You have never been a member of the RCGP.
To be determined

12. You submitted information to the IOT which was untrue.
To be determined

13. You knew that the information provided in the documents referred to at paragraph 10 above was untrue.
To be determined

14. Your actions as described as paragraphs 10 - 12 were dishonest by reason of paragraph 13.
To be determined

Work Details Form

~~15. You completed and signed a Work Details Form ('the WDF') on 5 March 2017 in which you failed to declare that you were sub-contracted to provide medical services to Frosts Pharmacy until 24 May 2017.~~
Withdrawn following a successful Rule 17(2)(g) application

~~16. When you completed the WDF, you knew you were sub-contracted to provide medical services to Frosts Pharmacy until 24 May 2017.~~
Withdrawn following a successful Rule 17(2)(g) application

~~17. Your conduct as described at paragraph 15 was dishonest by reason of paragraph 16.~~
Withdrawn following a successful Rule 17(2)(g) application

Suspension from the Medical Performers List

18. On 25 April 2017 you were suspended from the Medical Performers List and you failed to notify Frosts Pharmacy of this.
To be determined

19. You knew that you were required to inform Frosts Pharmacy of your suspension from the Medical Performers List.
To be determined

20. Your conduct as described at paragraph 18 was dishonest by reason of paragraph 19.
To be determined

Aneurin Bevan University Health Board

21. In July 2017 a review was initiated by Aneurin Bevan University Health Board ('the Health Board') into your on-line prescribing practices ('the Review') and you:

a. repeatedly frustrated the Health Board's attempts to carry out the Review in that you:

i. consistently challenged the Review where there was no basis to do so, in that you questioned the:

1. terms of reference; **To be determined**

2. competence of the investigators; **To be determined**

3. training of the investigators; **To be determined**

4. the proposed CQC methodology; **To be determined**

ii. continued to challenge the Review as set out at paragraph 21ai above when investigators visited your house on 5 October 2017, preventing any progress to the Review;
To be determined

~~b. failed to advise the Health Board throughout the period of the Review of open GMC investigations against you.~~
Withdrawn following a successful Rule 17(2)(g) application

22. During the Review, you knew that you were:

a. the subject of open GMC investigations;
To be determined

~~b. required to inform the Health Board of ongoing GMC investigations.~~
Withdrawn following a successful Rule 17(2)(g) application

~~23. Your conduct asset out at paragraph 21b was dishonest by reason of paragraph 22.~~
Withdrawn following a successful Rule 17(2)(g) application

Gender GP

24. Alongside Dr SS, you operate and control the company known as Gender GP, through which you provided care and treatment.
To be determined

~~25. As the principal provider of the Gender GP website, offering hormonal treatment to children, you failed to appropriately reference:~~

~~a. the input of any accredited paediatrician/paediatric specialist;~~
Withdrawn following a successful Rule 17(2)(g) application

~~b. your safeguarding policy.~~
Withdrawn following a successful Rule 17(2)(g) application

~~26. On the governance page of the Gender GP website it states that 'all medical advice and prescriptions are provided by doctors working outside of the UK'.~~
Withdrawn following a successful Rule 17(2)(g) application

~~27. The operating method of Gender GP as set out at paragraph 26 above is motivated by efforts to avoid the regulatory framework of the United Kingdom, including regulation by the:~~

~~a. CQC;~~ Withdrawn following a successful Rule 17(2)(g) application

~~b. HIW;~~ Withdrawn following a successful Rule 17(2)(g) application

~~c. GMC.~~ Withdrawn following a successful Rule 17(2)(g) application

Conviction

28. On 5 October 2018 at the Mid Wales (Merthyr Tydfil) Magistrates' Court you were convicted, contrary to Section 11(1) of the Care Standards Act 2000, in that you did:

a. carry on or manage an independent medical agency, namely Online GP Services Limited, without being registered under Part 11 of the Care Standards Act 2000; Admitted and found proved

b. as a director of Online GP Services Limited, consent to that company carrying on or managing an independent medical agency, namely Online GP Services, without it being registered under Part 11 of the Care Standards Act, thereby committing an offence contrary to section 30(2) of the Care Standards Act 2000.
Admitted and found proved

29. On 3 December 2018 you were sentenced to pay a fine in the sum of £12,000.00.
Admitted and found proved

And that by reason of the matters set out above your fitness to practise is impaired because of your:

a. misconduct as set out at paragraphs 1 – 27;

b. conviction as set out at paragraphs 28 - 29.

The Admitted Facts

32. Dr Webberley, through her Counsel made admissions to paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

The Facts to be Determined

33. In light of Dr Webberley's response to the Allegation made against her, the Tribunal determined the disputed allegations as set out above.

Evidence

34. The Tribunal received evidence on behalf of the GMC from the following witnesses, together with their witness statement(s) where provided:

- Professor F, Consultant in Paediatric and Adolescent Endocrinology, statements dated 12 September 2017 and 22 November 2018;
- Professor I, Paediatric Endocrine Consultant, statement dated 3 October 2017;
- Dr H, Patient A's GP, statement dated 17 September 2017;
- Dr J, Patient B's GP, statement dated 11 June 2018;
- Dr G, Patient B's treating Consultant Child and Adolescent Psychiatrist, statements dated 8 June 2018 and 30 June 2021;
- Dr K, Patient C's GP, statements dated 14 September 2018 and 29 June 2021;
- Mr L, Inspector for the CQC, statement dated 21 November 2017;
- Mr M, Head of Regulation and Investigation at Healthcare Inspectorate Wales (HIW), statement dated 12 September 2017;
- Dr N, Deputy Medical Director for Aneurin Bevan University Health Board ('the Health Board'), statements dated 18 October 2017 and 11 July 2021;
- Mr R, Managing Director of FPL, statements dated 22 September 2017 and 12 August 2021.

Expert Witness Evidence

35. The Tribunal heard evidence from the following expert witnesses on behalf of the GMC and received their reports:

- Dr O, a GP and a GP Trainer, reports dated 6 June 2018, 5 August 2018 and 6 February 2021;
- Dr S, former GP, reports dated 18 December 2019 and 19 March 2021;
- Dr P, Paediatric Endocrinologist, reports dated 19 March 2021 and 14 August 2021;
- Dr Q, Clinical Psychologist, reports dated 16 March 2021 and 20 August 2021;
- Dr T, Specialist Clinical Psychologist, report dated 19 July 2021.

36. The Tribunal heard evidence on behalf of Dr Webberley from the following expert witnesses, and received their reports:

- Dr V, Chartered Psychologist and Gender Specialist, report dated 19 August 2021;
- Dr U, Paediatric Endocrinologist, reports dated 22 August 2021 and 25 August 2021
- Dr W, Consultant in Transgender Health, reports dated 23 August 2021 and 5 September 2021.

Documentary Evidence

37. The Tribunal was provided with documentary evidence by both parties, which included but was not limited to:

- Bundle of witness statements together with corresponding exhibits;
- Medical records for Patients A, B and C;
- British Medical Association letter to the GMC regarding Specialist Prescribing, dated 12 May 2016;
- Undated complaint letter from Patient A's mother to the UCLH about the care and treatment to Patient A; together with the response from UCLH dated 24 October 2017;
- Patient A, statement dated 28 July 2021;
- Patient A's mother's statements dated 27 July 2021 and 30 July 2021;
- A note from GIRES to Sir UU, Chair of the Clinical Priorities Advisory Group (CPAG) dated 13 June 2016;
- Screenshots of website pages for Gender GP and sample screenshots from Dr Webberley's electronic patient records system;
- NHS Contract for GIDS dated 30 December 2019;
- National and International guidelines on the provision of care and treatment to transgender adolescent and adult patients;
- CQC Inspection Report of Tavistock and Portman NHS Foundation Trust Gender Identity Service (GIDS) dated 20 January 2021;
- Various correspondence exchange between Professor F those treating Patient A, B and C;

- Correspondence between Dr Webberley and others involved in the care and treatment of Patients A, B and C;
- Correspondence between HIW and Dr Webberley at Dr Matt Limited and associated documents; and Dr Matt Limited Training and Development Policy dated July 2013;
- Correspondence exchange between Dr Webberley and HIW; and between Dr Webberley and ABUHB;
- Memorandum of conviction dated 3 December 2018, and judgement.

38. Dr Webberley gave oral evidence and provided witness statements, dated 9 August 2021 and 26 August 2021.

The Legally Qualified Chair's Advice

39. The legal qualified chair provided the parties with a written advice as to the matters of law to which the Tribunal should have regard when determining the facts set out in the paragraphs of the Allegation. A copy of that advice is attached to this determination.

The Tribunal's Approach

40. In reaching its decision on the facts, the Tribunal has borne in mind that the burden of proof rests on the GMC. Dr Webberley 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 matters alleged are true.

41. The Tribunal gave consideration to the wording of paragraphs 1(k)(iv) and 5(i)(iv) of the Allegation, namely that:

> '….(Dr Webberley) failed to provide good clinical care in that she did not maintain an adequate record of, respectively, Patient A's and Patient C's care in that entries in records were
>
> iv. made using email print-offs rather than an electronic record

42. Dr S was provided with paper documents rather than the record which Dr Webberley kept in respect of each of her patients electronically. Accordingly, he was unaware of her system. The Tribunal determined that the gravamen of his evidence was that it was inappropriate for Dr Webberley to record the treatment and/or care of her patients by reference to emails which she drafted. The Tribunal considered the case of ***Council for the Regulation of HealthCare Professionals v GMC and Ruscillo [2004] EWCA Civ 1356***. It determined that it should not interpret these paragraphs of the Allegation as representing a criticism of Dr Webberley's record keeping by way of emails.

Introduction

43. The allegations against Dr Webberley in relation to her clinical care and treatment of Patient A, Patient B and Patient C are extensive and far reaching. In approaching the task of reaching a determination in respect of those allegations, it was first necessary for the Tribunal to set out its understanding of the framework of transgender healthcare in 2016 and 2017, the material time. This it has done in the section of this determination entitled: "The Framework of Transgender HealthCare". Next the Tribunal determined that it should form a view as to the overall competence of Dr Webberley as a General Practitioner with a special interest in gender dysphoria, a description of her used by the GMC in the paragraphs of the Allegation relating to Dr Webberley allegedly acting outwith the limits of her competence. Such a view is necessary if it is to reach a determination as to whether she was acting outwith the limits of that competence. It is also necessary when it considers specific paragraphs of the Allegation, particularly in relation to:

- whether she should have arranged for Patients A and / or Patient B to be psychologically assessed prior to prescribing testosterone, and / or so assessed or reviewed after starting them on testosterone;
- whether she should have arranged for full psychological pre-diagnostic input prior to prescribing GnRHa treatment;
- whether testosterone was appropriate for use in "children" of Patient A's age;
- whether she should have prescribed testosterone without the input of a multidisciplinary team;
- whether she correctly changed Patient B's prescription when he reported continued menstruation;
- whether she provided adequate follow-up care after initiating testosterone and / or GnRHa treatment;
- whether she assessed Patient A, Patient B and / or Patient C's capacity to consent to treatment;
- whether she obtained informed consent from Patient B in respect of his treatment;
- whether she should have engaged with a paediatric endocrinologist and / or a mental health practitioner before or during treatment of Patient A and / or Patient B;
- whether she was obliged to adhere to professional guidelines:
    - Endocrine Society Professional Guidelines (2009);
    - World Professional Association for Transgender Health Standards of Care (7th Edition).

44. The section of this determination which addresses this issue is entitled: 'Dr Webberley's competence as a GP with a special interest in gender dysphoria'. These two sections represent findings by the Tribunal on the evidence presented to it by the GMC and Dr Webberley. They are necessary steps to enable the Tribunal to arrive at and complete its determination on all the paragraphs of the Allegation against her which relate to Patients A, B and C.

The Framework of Transgender Healthcare

45. Paragraphs 2b, 4b and 6b of the Allegation relate to the care provided by Dr Webberley to Patients A, B and C respectively. The GMC alleged that in providing care to those patients, Dr Webberley knew or ought to have known that she was acting outwith the limits of her competence.

46. The Tribunal determined paragraphs 2b, 4b and 6b separately. However, the evidence before the Tribunal regarding the competencies required for the safe and effective care of transgender adolescents applied equally to all three patients. The Tribunal therefore finds it expedient to explain its reasoning in relation to paragraphs 2b, 4b and 6b within one narrative.

47. Patients A, B and C were three adolescent transmen who presented to Dr Webberley in 2016 with what was, at that time, referred to as gender dysphoria. They were aged 11 years and 10 months, 16 years and 3 months and 10 years and 7 months respectively, when they and/or their parent first contacted Dr Webberley for help.

48. The care in question involved the diagnosis and assessment of gender dysphoria, the prescription of testosterone to initiate a masculine puberty to Patients A and B and the prescription of GnRHa to arrest endogenous puberty in Patients B and C.

49. The GMC case in respect of paragraphs 2b, 4b and 6b of the Allegation was summarised by Mr Jackson QC in his opening note. He stated: 'Dr Helen Webberley did not have the required 'competence' (referenced in GMP) to embark on the role of lead clinician in the provision of such care, in a primary care context, with all its associated complexities – rather, it was for her to restrict her role to prescribing such medication in the context of a multidisciplinary team ('MDT') approach, with its important and essential prior input from specialists, such as from a paediatric endocrinologist, and having obtained detailed psychological assessment, as outlined in the NHS Guidance.'

50. The GMC case against Dr Webberley was therefore built on a view that the care of transgender adolescents is complex and that, in consequence, the care of Patients A, B and C could only be delivered within a multidisciplinary team with input from specialists, particularly those from the disciplines of psychology/psychiatry and paediatric endocrinology. The GMC alleged that Dr Webberley, a GP, was not competent to deliver the care in question and that it was not delivered within a multidisciplinary team setting.

51. Dr Webberley was reported to the GMC by fellow doctors. The GMC has received no complaints about Dr Webberley from any patients. Mr Stern, on behalf of Dr Webberley, stated in his closing submissions:

> *'This is the oddest of cases. No one has suggested that each of the patients did not suffer from gender dysphoria. No one has suggested that the treatment for gender dysphoria in this case is not puberty blockers and/or testosterone. None of the patients has complained about the care they received from Dr Webberley. Quite the contrary, the mother of Patient A and the mother of patient C were asked to provide*

statements to the GMC and the GMC obtained statements from them. Each is glowing in their support of Dr Webberley and each views the care that she provided to their son as life-saving.'

52. The Tribunal acknowledges that there have been no complaints made to the GMC about Dr Webberley from any patients. It finds, however, that whilst successful outcomes may evidence competence, it does not follow that an absence of complaints confirms competence. An incompetent doctor puts patients at risk of harm, even if that risk does not lead to actual harm. The Tribunal therefore makes clear from the outset of this determination its unequivocal endorsement of the tenet that doctors must practise within the limits of their competence.

Clinical Practice Guidelines

53. Dr Webberley's involvement in the care of Patients A, B and C took place in 2016 and 2017.

54. The GMC case was that two clinical practice guidelines, namely 7th edition of the World Professional Association for Transgender Health's Standards of Care (2012) (WPATHSOC7) and the Endocrine Society's Clinical Practice Guidelines (2009) (Endocrine Society Guidelines 2009), represented the benchmarks in transgender healthcare at the material time. WPATHSOC7 and Endocrine Society Guidelines 2009 underpin the NHS England's GIDS, which the GMC held out as the paradigm with which Dr Webberley's practice should be compared and contrasted.

55. WPATH is 'an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transsexual and transgender health.'

56. WPATHSOC7 is a comprehensive manual aimed at clinicians who provide healthcare to transgender persons of all ages. The component sections were written by eighteen invited experts: twelve from North America/Canada, five from two centres in Europe and one from Hong Kong. There were no authors from the UK.

57. Work began on WPATHSOC7 in 2006 and the component sections were published in peer-reviewed journals in 2009. A draft WPATHSOC7 was produced in March 2011 and the final version was published in the August 2012 edition of the International Journal of Transgender Health.

58. WPATH was funded by the Tawani Foundation and an anonymous donor.

59. The Tribunal therefore finds that WPATHSOC7 has the status of peer-reviewed expert guidance. The Tribunal also notes that the groundwork that led to WPATHSOC7 had begun ten years before Dr Webberley provided care to Patients A, B and C and that transgender

healthcare was an evolving discipline during the material time. It also notes the absence of any contributions from UK transgender healthcare practitioners.

60. The introduction to WPATHSOC7 states 'The SOC are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender-nonconforming people.' WPATHSOC7 does not prescribe a rigid protocol for the delivery of care, but instead provides guidance on the components of a comprehensive service and makes recommendations as to the credentials of those delivering the service.

61. Transgender healthcare services for children and adolescents should, according to WPATHSOC7, be provided by a multidisciplinary team that includes, inter alia, mental health professionals and paediatric endocrinologists.

62. Mental health professionals are central to the WPATHSOC7 vision of how transgender healthcare services should operate. Their role may, according to WPATHSOC7, include assessment of gender dysphoria, provision of family counselling and psychotherapy, assessment and treatment (or onward referral for treatment) of 'coexisting' mental health concerns, onward referral for physical interventions such as hormone therapy, education and advocacy and signposting to information and sources of peer support.

63. WPATHSOC7 places emphasis on the need for mental health screening and states 'Clients presenting with gender dysphoria may struggle with a range of mental health concerns whether related or unrelated to what is often a long history of gender dysphoria and/or chronic minority stress. Possible concerns include anxiety, depression, self-harm, a history of abuse and neglect, compulsivity, substance abuse, sexual concerns, personality disorders, eating disorders, psychotic disorders, and autistic spectrum disorders. Mental health professionals should screen for these and other mental health concerns and incorporate the identified concerns into the overall treatment plan.'

64. WPATHSOC7 further states 'A mental health screening and/or assessment as outlined above is needed for referral to hormonal and surgical treatments for gender dysphoria.'

65. WPATHSOC7 therefore places the mental health professional in the role of gate-keeper, through which those seeking access to gender-affirming therapy must pass.

66. WPATHSOC7 recommends that the minimum credentials of mental health professionals working with children and adolescents presenting with gender dysphoria should be a master's degree or equivalent in clinical behavioural science; competence in using the American Psychiatric Association's Diagnostic Statistical Manual (DSM) and/or the World Health Organisation's International Classification of Diseases (ICD); the ability to recognise and diagnose 'coexisting' mental health concerns; supervised training and competence in psychotherapy or counselling; knowledge of gender-nonconforming identities and the assessment and treatment of gender dysphoria; training in childhood and adolescent developmental psychopathology; and competence in diagnosing and treating the ordinary problems of children and adolescents.

67. Although WPATHSOC7 refers in one instance to the involvement of paediatric endocrinologists, the remaining guidance uses the more general term 'hormone-prescribing physician'.

68. The responsibilities of the hormone-prescribing physician identified in WPATHSOC7 include, inter alia: to perform an initial evaluation that includes discussion of a patient's physical transition goals, health history, physical examination, risk assessment, and relevant laboratory tests; to discuss with patients the expected effects of feminising/masculinising medications and the possible adverse health effects, including a reduction in fertility; to confirm that patients have the capacity to understand the risks and benefits of treatment and are capable of making an informed decision about medical care; to provide ongoing medical monitoring, including regular physical and laboratory examination to monitor hormone effectiveness and side effects.

69. As to the credentials of the hormone-prescribing physician, WPATHSOC7 states 'With appropriate training, feminizing/masculinizing hormone therapy can be managed by a variety of providers, including nurse practitioners, physician assistants, and primary care physicians'.

70. The second set of guidelines advanced by the GMC as a benchmark in transgender healthcare was the Endocrine Society Guidelines 2009.

71. The Endocrine Society Guidelines 2009 is, according to Dr P's oral evidence:

> *'regarded as the international authority towards endocrine treatment in general'*.

72. Endocrine Society Guidelines 2009 was formulated by a sub-committee of the Endocrine Society. Preliminary drafts of the Guidelines were commented on by members of the Endocrine Society, the European Society of Endocrinology, the European Society for Paediatric Endocrinology, the Lawson Wilkins Pediatric Endocrine Society and WPATH. The Tribunal therefore finds that Endocrine Society Guidelines 2009 had the status of peer-reviewed expert guidance.

73. Endocrine Society Guidelines 2009 endorsed the then prevailing WPATH guidelines (WPATH-SOC6) regarding the gate-keeper role of the mental health professional but, surprisingly for a document written by endocrinologists, it contained no guidance concerning the training or competencies required of a hormone-prescribing physician. Endocrine Society Guidelines 2009 did state, however, that 'treating endocrinologists confirm the diagnostic criteria of GID or transsexualism and the eligibility and readiness criteria for the endocrine phase of gender transition' and that 'endocrinologists review the onset and time course of physical changes induced by cross-sex hormone treatment.' Endocrine Society Guidelines 2009 therefore apparently envisaged that endocrinologists would have at least some involvement in the hormone therapies prescribed to transgender persons undergoing gender transition. The Tribunal notes that Endocrine Society Guidelines 2009 assigns responsibility for confirming the diagnosis of gender dysphoria to the hormone prescriber. The Tribunal

finds it difficult to reconcile the roles of hormone prescriber and diagnostician if the former is an endocrinologist and the diagnosis is a mental illness.

74. Endocrine Society Guidelines 2009 states that to be eligible to receive gender-affirming hormones, an adolescent must be aged sixteen or over. This stipulation has the status of a 'suggestion', as opposed to a 'recommendation', and was based on 'very low quality evidence.' The evidence on which it was based was a 2006 paper published by pioneers in transgender healthcare at the Amsterdam Gender Clinic. The authors of that 2006 paper stated: 'As in many European countries, in the Netherlands, 16-year olds are considered legal adults for medical decision-making.' The age eligibility criterion of sixteen in Endocrine Society Guidelines 2009 therefore had a legal basis, not a medical or biomedical basis.

75. Endocrine Society Guidelines 2009 provides guidance on the staging of puberty (so-called Tanner staging), posology (dosing); the monitoring of patients during follow-up and various other clinical matters relating to safe and effective care.

76. Both WPATHSOC7 and Endocrine Society Guidelines 2009 advocate a staged approach to physical interventions in transgender healthcare. WPATHSOC7 refers to three stages of treatment. Stage-1 involves the arresting of endogenous puberty through the administration of medications such as GnRHa. Stage-2, which may be initiated whilst Stage-1 is ongoing, is the administration of gender-affirming hormones to induce transgender puberty. Stage-3 is the surgical remodelling of the body. Stage-1 interventions are regarded as fully reversible, although concerns have been raised that protracted use of GnRHa may impact adversely on skeletal health; stage-2 as partially reversible and stage-3 as irreversible.

77. WPATHSOC7 provides a rationale for a staged approach as follows: 'A staged process is recommended to keep options open through the first two stages. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions.' Neither WPATHSOC7 nor Endocrine Society Guidelines 2009 specify the time that should elapse between stages.

The NHS England Gender Identity Development Service (GIDS)

78. GIDS was at the material time, and remains to date, the only NHS service catering for the care needs of transgender children and adolescents in England.

79. GIDS was commissioned by NHS England (NHSE) and is provided by TPFT, with clinics held in London and Leeds. Paediatric endocrinology liaison clinics, a key component of GIDS, are provided by UCLH and by Leeds Teaching Hospitals NHS Trust under subcontract to GIDS.

80. The Tribunal did not receive any evidence from GIDS, but was assisted in its understanding by Service Specification E13/S(HSS)/e, which forms Schedule-2 of the NHSE-GIDS contract, and by the evidence of GMC witness Professor F, the Medical Endocrine Lead for GIDS.

81. Service Specification E13/S(HSS)/e states that GIDS will be delivered in line with

> *'emerging evidence for best practice; relevant national and international guidelines for the care of children and adolescents with GD such as the World Professional Association for Transgender Health Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming people, (Version 7 2012) and the Endocrine Society Guidelines 2009; NICE guidelines specific to the treatment of mental and emotional health and wellbeing including for psychosis, anxiety and depression.'*

82. The Tribunal was informed that there were no NICE guidelines specifically relating to the treatment of gender dysphoria at the material time, nor have any been developed to date.

83. Thus, whilst GIDS is contractually obliged to deliver its service in line with emerging evidence for best practice, it is in reality tethered to WPATHSOC7 and Endocrine Society Guidelines 2009.

84. The TPFT limb of GIDS is, according to the evidence provided to the Tribunal, a child and adolescent mental health service (CAMHS) in all but name. Thus, E13/S(HSS)/e states 'The psychological element of the service is a Tier 4 mental health service which will support children and young people to understand their gender identity.' 'Tier 4' is a reference to the stratification of CAMHS facilities in England, with Tier-1 the entry level and Tier-4, which includes specialised inpatient units and facilities, such as GIDS, delivering intensive community services, the highest.

85. E13/S(HSS)/e goes on to state 'It [GIDS] will be delivered through a highly specialist multidisciplinary team (MDT) with contributions from specialist social workers, family therapists, psychiatrists, psychologists, psychotherapists, paediatric and adolescent endocrinologists and clinical nurse practitioners.'

86. The GIDS assessment pathway begins with a referral, often from a local CAHMS or a GP, which is 'discussed by the intake team'. Patients are then accepted onto a waiting list for a first appointment, or further inquiries are made, following which the patient is accepted onto the waiting list or rejected. A telephone triage call follows to 'assess risk and signpost'. Consultation with the referrer then takes place and there is a 'local network meeting'. Service users who are accepted by GIDS now enter an 'Assessment Phase', following which the possible outputs are: 'Further Assessment, Occasional Contact: ~6 monthly+; GIDS input ~3 monthly; Refer to Endocrinology Clinic + ongoing GIDS input and/or Refer to other services, e.g. adult gender services.'

87. Those service users who have stayed the course (waiting times are discussed later in this determination) and deemed eligible for onward referral to the GIDS paediatric endocrine liaison clinic enter a second pathway. The service user receives a '1st Appointment in group format attended by family/carer, client, GIDS clinician, Paediatric Endocrine Liaison Clinic

staff'. Those under sixteen and 'complex cases' receive a '1st Appointment with Endocrine Consultant, +/- Endocrine nurse, family/carer, client & GIDS clinician.' Physical tests 'to assess for hormone (hypothalamic) blocker' take place at the first appointment and before the first follow-up. The first follow-up takes place two to three months after the first appointment and a decision regarding treatment is made. For those deemed eligible for endocrine treatment, the GP is asked to prescribe and administer a puberty blocker. There then takes place 'Regular follow up by telephone or in clinic with Consultant/Clinical Nurse Specialist/the Service staff as appropriate 3 to 6 monthly as required'. When access criteria are met (a key criterion being the minimum age of sixteen) a decision is made 'regarding cross sex hormones'. Follow-ups continue until service users reach their eighteenth birthday before discharge or referral to an adult service.

88. The assessment phase specified in E13/S(HSS)/e replicates guidance in WPATHSOC7 concerning the psychological assessment of children and adolescents with gender dysphoria. WPATHSOC7 describes the approach to, and the content of, such assessments, but it does not specify how long the assessment phase should take, nor does it stipulate how many assessment sessions are necessary.

89. E13/S(HSS)/e is rather more specific in that it states that mental health professionals are to 'offer a thorough assessment for gender dysphoria and any coexisting mental health concerns'; a *'psychodiagnostic and psychiatric assessment covering the areas of emotional functioning, peer and other social relationships, and intellectual functioning/school achievement'* and *'inform youth and their families about the possibilities and limitations of different treatments'*.

90. E13/S(HSS)/e further states *'There will be a multi-factorial assessment to enable the Lead Worker to gain a broad picture of the client's previous and current gender identification, as well as their development across a number of domains (education, family relationships, peer relationships), with a particular focus on any associated psychological difficulties that may impact on future development and response to treatment.'*

91. The Tribunal notes that E13/S(HSS)/e specifies: *'The Service will only accept referrals for children and adolescents with features of GD [gender dysphoria] which are consistent with the current diagnostic criteria as defined in DSM-5.'* Thus, in order to be accepted by GIDS, a service user must already have met, or at least exhibit symptoms consistent with, the DSM-5 criteria for gender dysphoria. Such a strict acceptance policy should, in the Tribunal's view, logically act as a filter and thereby reduce the need for a lengthy diagnostic phase, which is hard to reconcile with Professor F's evidence that 'The psychological assessment usually takes between 6 and 12 months.

92. E13/S(HSS)/e nevertheless states: *'In this initial assessment/consultation phase, clients and carers will be seen every one to three months, although this may be more or less frequent as needed.'* E13/S(HSS)/e goes on *'The exact content and manner of delivery will be dependent on the developmental stage and age of the client. Where the client's situation is complex, that is, has a number of health conditions or psychosocial adversities in addition to*

the GD presentation, the Service will, as appropriate, undertake joint 'network' meetings with the client, their family or carers, their GP, CAMHS provider, school, secondary care paediatrician and others to ensure the appropriate care.'

93. Professor F described the psychological assessment pathway at GIDS when giving evidence relating to Patient A. He explained:

> *'The diagnosis is not made by one person, as each case, not just Patient A's, is discussed by the whole of the gender dysphoria team which consists of around forty people. The team carefully discuss each young person's case and decide whether they are eligible for treatment and what support the family need. The psychological assessment usually takes between 6 and 12 months and is fundamental to our processes'.*

94. Thus, to access endocrine interventions, GIDS service users must undergo multiple stepwise or concomitant assessments by multiple mental health professionals over a period of many months to establish a psychiatric diagnosis of gender dysphoria and to confirm persistence of gender dysphoria; assessments by psychiatrists or psychologists to exclude 'comorbid' psychopathology, or to assess psychopathology if present; and, if deemed eligible, further assessment by a paediatric endocrinologist, clinical nurse specialist and counsellors and/or psychologists to create and implement an endocrine treatment plan.

95. The protracted nature of the assessment phase in the GIDS care pathway appears to be based, at least in part, on evidence that gender dysphoria in pre-pubertal children is often self-remitting.

96. Thus, E13/S(HSS)/e cites a 2005 paper, which concluded *'It's clear that, for the majority of gender-confused boys and girls, gender dysphoria desists over time as they enter adolescence.'* That said, such observations apparently informed Professor F's evidence to the Tribunal, in which he stated: 'it is imperative that practitioners do not *'jump the gun'* in relation to commencing young people on hormone blocker treatment before they have been carefully assessed.'

97. This approach appears to overlook guidance in WPATHSOC7, which states: *'An important difference between gender dysphoric children and adolescents is in the proportion for whom dysphoria persists into adulthood. Gender dysphoria during childhood does not inevitably continue into adulthood. … In contrast, the persistence of gender dysphoria into adulthood appears to be much higher for adolescents. … in a follow-up study of 70 adolescents who were diagnosed with gender dysphoria and given puberty-suppressing hormones, all continued with actual sex reassignment, beginning with feminizing / masculinizing hormone therapy'.* The distinction between gender dysphoria in children and in adolescents is therefore clearly crucial. Gender dysphoria manifesting before puberty (i.e. in children) is often self-remitting, whereas gender dysphoria persisting into puberty or manifesting itself during puberty is far more likely to require gender-affirming therapy.

98. The evidence that almost all adolescents that opt to undergo puberty suppression will go on to request gender reassignment via gender-affirming hormone therapy was accepted in the ***Bell v Tavistock [2020] EWHC 3274 (Admin)*** judicial review.

99. The judicial review found that:

> *'There is some dispute as to the purpose of prescribing PBs [puberty blockers]. According to Dr VV, the primary purpose of PBs is to give the young person time to think about their gender identity. This is a phrase which is repeated on a number of the GIDS and Trust information documents. The Health Research Authority carried out an investigation into the Early Intervention Study in 2019. Its report was somewhat critical of the description of the purpose …'*.

In summary, adolescents that consent to puberty blockers do not need 'time to think about their gender identity': they are already settled in their mind and almost invariably seek gender-affirming (stage-2) hormone therapy.

100. The Tribunal finds that GIDS is based on expert guidance and that it takes a very cautious and thorough approach to the assessment of its service users. However, whilst E13/S(HSS)/e specifies that 'This [the service] will be holistic and tailored to the needs of the individual and their family/carers.', the Tribunal finds, on the evidence of Professor F, that GIDS has an unyielding protocol-driven approach to its psychological assessment phase. Far from being tailored to the needs of individual service users, it evidently imposes a one-size-fits-all diagnostic/assessment protocol. Access to hormone therapy via GIDS is, moreover, dependent upon service users meeting DSM-5 criteria for gender dysphoria and thereby accepting that they have a mental illness.

101. These findings are particularly relevant to this case, given the gate-keeper status of the mental health practitioner, as specified in WPATHSOC7 and Endocrine Society Guidelines 2009, and the body of opinion that was growing at the material time that gender dysphoria is not, in fact, a mental illness.

The Evolving Nature of Transgender Healthcare

102. The evidence placed before the Tribunal persuaded it that transgender healthcare was an evolving medical discipline at the material time and that opinion was, and still is, divided amongst experts as to the optimal approach to caring for those transgender persons who experience gender dysphoria.

103. The Tribunal therefore summarises the evidence it received regarding the evolving nature of transgender healthcare during and leading up to Dr Webberley's involvement in Patients A, B and C. The Tribunal does so in order to assess Dr Webberley's competence by reference to existing and emerging practice.

104. Gender dysphoria was, at the material time, and still is, as far as the American Psychiatric Association (APA) is concerned, a mental illness. The term 'gender dysphoria' first appeared in the fifth edition of APA's DSM (DSM-5, 2013). APA had previously used the term 'gender identity disorder' (DSM-4, 1994).

105. The World Health Organisation (WHO) also classified gender dysphoria as a mental illness at the material time. Thus, the 10th iteration of the WHO International Classification of Disease (ICD10) uses the term 'gender identity disorder' and placed it within the mental, behavioural and neurodevelopmental disorder section of that nosology.

106. The Tribunal received evidence that transgender persons regard the word 'disorder' as 'pathologizing or stigmatizing'.

107. The next iteration of the WHO ICD (ICD11) addresses that point by replacing 'gender identity disorder' with the term 'gender incongruence'.

108. The Tribunal finds that this change in terminology is far more than merely a relabelling exercise: it evidently reflects a fundamental shift in medical and societal attitudes to transgenderism. Gender incongruence is not to be found in the section of ICD11 dealing with mental ill health; rather, it is in the section concerned with conditions related to sexual health.

109. Thus, gender dysphoria is no longer to be regarded as a mental illness. This is because transgenderism itself is now regarded as a somatic (i.e. bodily; corporeal; physical) state of being, not a state of mind. This re-thinking is based on evidence that gender identity is innate, rather than learned:

- Males (persons with an XY karyotype) who are raised as girls due to developmental sex abnormalities or following trauma to the penis in infancy (due, for example, to botched circumcision) experience gender dysphoria in childhood and are discontent with the feminine phenotype and gender role imposed upon them.
- Male (XY) foetuses exposed to abnormally low levels of androgens in utero are more likely to develop into transwomen. Female (XX) foetuses exposed to abnormally high levels of androgens in utero are more likely to develop into transmen.
- Adult transgender individuals often report a lifelong history of gender dysphoria which they had hidden in their formative years due to shame and/or social/family pressures.
- There is post-mortem evidence that the structural neurobiology of the brain is involved in the establishment of gender identity.

110. The enlightened thinking embraced in ICD11 regarding the somatic nature of transgenderism is not reflected in Endocrine Society Guidelines 2009, which states, contrary to ample extant evidence, that *'One's self-awareness as male or female evolves gradually during infant life and childhood.'* This view of the aetiology of transgenderism is repeated verbatim in the 2017 update of the Endocrine Society's Clinical Practice Guideline. Even the

Royal College of Psychiatrists (RCPsych) stated that gender dysphoria is 'developmental' in nature in their 1998 publication Guidance for the management of gender identity disorders in children and adolescents.

111. The Tribunal finds that the reluctance of the Endocrine Society and others to embrace enlightened views of transgenderism is symptomatic of the tendency in all professions to be slow to move with the times. This inertia in respect to medical attitudes to transgenderism mirrors past attitudes to homosexuality, which was classified by the APA as a mental illness until the 1973 edition of their DMS.

112. ICD11 came into effect in January 2022 and with it the reclassification of gender dysphoria from a mental illness to a condition related to sexual health. This did not mean, of course, that the nature of gender dysphoria itself changed on 1 January 2022: it is merely the system of nosology that changed. Importantly, the Tribunal finds that at the material time (2016/17), those with an interest in transgender healthcare, such as Dr Webberley, would have been aware that there was a growing body of opinion that gender dysphoria should cease to be considered a psychiatric disorder. Thus:

- The drive to change the medical approach to gender dysphoria was given impetus when WPATH released a statement in May 2010 urging the 'de-psychopathologisation of gender nonconformity worldwide'.
- In the same year, gender reassignment became a protected characteristic under the Equality Act 2010.
- The new thinking embodied in ICD11 during its drafting and consultation phase had provoked comment in the medical literature since at least 2012.
- Dr S, in his oral evidence, referred to an e-learning module hosted at the material time by the Royal College of General Practitioners and stated: 'It made a strong emphasis on the, excuse the long word, de-psychopathologisation, that being transgender diverse isn't a disorder, that it isn't a mental health condition, that gender diverse people may experience mental health, common mental health problems more frequently than the general population, but that is not inherent in them being gender diverse.' Dr Webberley completed that e-learning and was therefore aware of the evolving opinion in transgender healthcare that being transgender is not a mental illness.

113. The Tribunal also finds that the ICD is a reference manual and not a practice manual. There was no evidence placed before the Tribunal to suggest that the ICD10 mandated that clinicians treat transgenderism as a mental illness prior to January 2022 and that ICD11 mandates that transgenderism is treated as a sexual health condition from 2022.

114. The Tribunal finds that the 'de-psychopathologisation' of gender dysphoria and the contemporaneous rethinking in 2016/17 that transgenderism was no longer to be regarded as mental illness, is highly relevant to this case. The reclassification of transgenderism as a somatic state related to sexual health, as opposed to a mental illness, had clear implications

for the competencies necessary to deliver safe and effective care to those presenting with gender dysphoria.

115. It is Dr Webberley's case that, as an experienced GP and a doctor with a longstanding professional interest in sexual health, in the healthcare needs of minorities, such as gender-variant persons, and in the administration of hormone therapies, she was competent to provide safe and effective care to Patients A, B and C.

116. The Tribunal has therefore examined the competencies of a GP with a special interest in gender dysphoria. The Tribunal noted that there had been no challenge by the GMC that Dr Webberley was, at the material time, a GP with a special interest in gender dysphoria.

Dr Webberley's Competence as a GP with a Specialist Interest in Gender Dysphoria

Dr Webberley's Education and Training in Transgender Healthcare

117. The GMC case was that 'Dr Webberley is entirely self-validated' as a GP with a special interest in gender dysphoria.

118. Dr Webberley obtained a diploma in psychosexual medicine in 2002; she undertook career grade training in sexual and reproductive health in 2006 and attained membership of the Faculty of Reproductive and Sexual Health in 2007. The extent to which these attainments were or were not relevant to transgender healthcare was not explored in cross-examination, but the titles of these credentials suggest that they may have been of at least some relevance, given the reclassification of gender dysphoria as a condition related to sexual health.

119. Dr Webberley's evidence was that transgender healthcare did not feature on the undergraduate medical curriculum when she trained between 1987 and 1992 and that there were no postgraduate training courses in gender dysphoria at the material time. This evidence was not disputed by the GMC and was supported by other evidence, such as that of Dr S.

120. Professor F confirmed that there were no specific training courses for paediatric endocrinologists practising in transgender health at the material time or at any time since. He stated:

> *'This is something that has been debated in particular by the Royal College of Physicians and Royal College of Psychiatrists with the British Association of Gender Identity Specialists as to what the qualification should be because this is a new field of medicine. So, as yet there is no actual qualification, but there is in the process of developing an appropriate qualification.'*

121. The Tribunal therefore finds that any doctor practising in transgender healthcare in the UK at the material time could be described as 'self-validated' in that there were no

independently validated qualifications in what Professor F referred to as *'a new field of medicine'*.

122. The Tribunal received evidence that the only UK training in transgender healthcare offered by the RCGP at the material time was a basic introductory e-learning module, which Dr Webberley completed in 2015. This module has now been deleted from the RCGP website.

123. The Tribunal understands that at the material time the RCGP recognised GPs with a Special Interest (GPSI), now rebadged General Practitioners with Extended Roles (GPwER), in certain fields of general practice, such as child health, dermatology and emergency medicine. To acquire the status of an RCGP validated GPSI, GPs were required to present evidence of training and educational accomplishments to an RCGP committee. The Tribunal received evidence that Dr Webberley was contemplating making an application to the RCGP for GPSI status at the material time. To that end, Dr Webberley's visited the Gender Clinic at Danetre Hospital in Daventry on 18 November 2016, following which Dr Z wrote to her, stating:

> *'With your background of sexual health and generalist knowledge, I think there is nothing to prevent you seeking further training and support, mentoring and membership of a peer group with the intention of applying to be included on the list of specialists in the field of gender dysphoria.'*

124. Dr S, in his roles as 'Chair, NHS Clinical Reference Group for Gender Identity Services (2013-2022)' had evidently been working to address the lack of training courses in transgender healthcare. He stated:

> *'Through this role, I have been the acting clinical lead for the development of academic qualifications (Credentials; Postgraduate Certificate and Diploma, University of London) in Gender Identity Healthcare Practice, working with the Royal College of Physicians to develop a career, training and accreditation pathway for medical practitioners working in this discipline.'*

125. Dr Webberley herself had been striving to educate fellow GPs in the care of transgender patients. She published an article in 'Pulse', a monthly news magazine and website aimed at GPs. The article was titled 'Why do GPs have to prescribe for gender dysphoria?' Dr Webberley had also tried to engage with the GMC in advancing the educational opportunities for GPs in regard to transgender healthcare: 'I offered my services, as a doctor and educator, and started to develop and formulate protocols and provision that was in line with the International guidance that seemed the most evidence-based and affirmative for patients. I reached out to the GMC to offer to help develop training materials for doctors and had several good discussions about the challenges faced by patients and doctors.'

126. The lack of accredited and/or recognised training and educational avenues in transgender healthcare in the UK was acknowledged by the NHS at the material time. Thus,

the NHSE Operational Research Report published in 2015 following audits of Gender Identity Clinics in England published stated:

> *'There are no accredited/regulated training posts for clinicians working in Gender Clinics. Training is by 'apprenticeship' and any GIC [gender identity clinic] that increases its clinical complement offers such apprenticeships. There are very few training places …'*.

127. Dr Webberley was asked whether there were any apprenticeship opportunities at the material time. She replied:

> *'Again, not that I came across. It was my understanding that the clinics were all desperate for new recruits and there didn't seem to be opportunities to sit in and learn by apprenticeship because the field was very stretched in its capacity. The biggest clinic was in London, which was what was then called the Charing Cross Clinic but unfortunately, and I hate to say this, again, history showed that they didn't welcome practitioners, particularly private practitioners, in this field and actually quite early on two of the practitioners raised their own concerns about me being a doctor in this field. So it wasn't a friendly group to try and join, if I may, and that is why I was so delighted when Dr Z and I were able to connect and I went up to his clinic and we joined. You can see from his letter that he offered me continuing engagement but, of course, things overtook us and I wasn't able to work.'*

128. It was the GMC's case that, notwithstanding the lack of any training opportunities in the UK, Dr Webberley could have secured a traineeship 'even if it involved travelling abroad to get training'.

129. The Tribunal acknowledges that Dr Webberley could have pursued postgraduate training abroad, but was not persuaded that it was incumbent on her to do so. She had availed herself of such continuing professional development opportunities that were available at the material time through necessarily self-directed journal reading, and had developed a professional network that included meetings with gender specialists, including Dr S, Professor F, Dr Z and Dr X. Dr Webberley was evidently familiar with clinical guidelines such as WPATHSOC7 and Endocrine Society Guidelines 2009 and had attended symposia, such as the WPATH convention in Amsterdam in 2016, at which she had presented an audit of her transgender practice.

130. In Dr Webberley's words:

> *'I reached out to NHS gender specialist colleagues to form networks and peer support, and went to visit Dr Z in Northampton GIC [gender identity clinic] to sit in with him in clinic and discuss patients.'*

131. The Tribunal finds that Dr Webberley was hampered by the lack of formal training opportunities in transgender health at the material time and that her lack of validated qualifications in transgender healthcare cannot, therefore, be held against her.

132. For the avoidance of doubt, the Tribunal does not suggest that Dr Webberley was free to dabble in a field of medicine in which she lacked competence merely because there were no certificates or diplomas available. In fact, Dr Webberley did take appropriate steps through continuous professional development and networking to pursue an 'apprenticeship'. She also applied her prior experiential learning as an experienced GP with validated qualifications in sexual health to a nascent, but related, field of medicine. She had successfully undergone appraisal at ABHUB during the material time in order to maintain her GMC licence to practise. Dr Webberley's transgender practice was considered as part of that appraisal and no concerns about it were raised by Dr OO, her appraiser and Responsible Officer. The Tribunal note that appraisal was a process introduced by the GMC for the very purpose of identifying under-performing or incompetent doctors.

Dr Webberley's Competence as a Mental Health Professional

133. WPATHSOC7 specifies that the mental health professional should hold 'A master's degree or its equivalent in a clinical behavioural science field. This degree, or a more advanced one, should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented credentials from a relevant licensing board or equivalent for that country.'

134. Dr Webberley was referred to the WPATHSOC7 specifications for a mental health professional when giving her evidence and she stated:

> *'if I might just explain that in – again in America the situation is that, in order to receive gender affirming care there's a requirement for a letter of referral and I think that perhaps has been missed in this tribunal so far and maybe Dr W when he comes can explain it better, but there's this requirement in America for this letter of referral and that comes from traditionally when WPATH was written in 2011 – that letter of referral comes from usually a psychologist or a psychiatrist. In terms of UK practice, although I fully and highly respect the role of psychologists and psychiatrists in all aspects of medicine, we've learnt over the years that gender incongruence isn't a mental health disorder and although some patients do present with mental health difficulties, there isn't necessarily an exact requirement for an assessment of somebody's gender identity by specifically a psychologist or a psychiatrist.'*

135. When Dr Webberley was questioned again on this point the following day, she stated:

> *'I am fulfilling the role as the assessor, and I have a masters degree or equivalent in medicine, which allows me and qualifies me to undertake the assessments that I have spoken about. This list here on page 176 [the WPATHSOC7 list of credentials for a mental health professional] is designed for the kind of American – what do you call it –*

I can't think of the word – descriptor of what in their models of care – it is like I talked about yesterday, the letter that is required for referral for insurance purposes for this field.'

136. The Tribunal has already noted that WPATHSOC7 was written largely by practitioners in North America and that there were no authors from the UK. The Tribunal accepts Dr Webberley's evidence that the qualifications for the mental health professional specified in WPATHSOC7 were written to reflect requirements in the USA for letters of referral to come from persons holding particular credentials in clinical psychology. There are no such requirements in the UK, and the specifications of a mental health professional in WPATHSOC7 are therefore not applicable to the UK.

137. Dr Webberley's evidence that *'some patients do present with mental health difficulties'* was in accordance with other evidence received by the Tribunal that, notwithstanding the somatic nature of transgenderism, some, perhaps many, transgender persons experience poor mental health.

138. WPATHSOC7 states: *'It is relatively common for gender dysphoric children to have coexisting internalizing disorders such as anxiety and depression.'*

139. It was the evidence of Dr S that *'Some patients, as a consequence of incongruence, find life intolerable. They experience extreme levels of psychological distress, which may manifest as anxiety and depression.'*

140. Dr T explained that mental ill health in transgender persons is a reaction to 'minority stress'. Following a question from the Tribunal, she elucidated this point:

'I think that our society continues to be very gendered and very binary and we continue to grow up under the pressure of societal expectations based on our assigned sex at birth and what people expect our gender to be. Those prescribed gender rules and expectations are very damaging for people who don't identify with the gender that they've been assigned at birth or the sex that they've been assigned at birth and growing up in a society in which you feel you don't fit, there's a sense of minority stress which can be very damaging.'

141. WPATHSOC7 explains that:

'Minority stress is unique (additive to general stressors experienced by all people), socially based, and chronic, and may make transsexual, transgender, and gender-nonconforming individuals more vulnerable to developing mental health concerns such as anxiety and depression.' and: *'However, these symptoms [psychological distress] are socially induced and are not inherent to being transsexual, transgender, or gender-nonconforming.'*

142. NHS information for the public states: *'Puberty may cause such intense anxiety in some young trans people that they are extremely vulnerable to depression and even suicidal feelings.'*

143. The Tribunal therefore received evidence that poor mental health occurs in a proportion of transgender persons and that it is a reaction to minority stress. The onset of puberty may heighten anxiety in a transgender person, as it heralds the emergence of the very secondary sexual characteristics that conflict with that person's gender identity.

144. WPATHSOC7 states: *'The presence of coexisting mental health concerns does not necessarily preclude possible changes in gender role or access to feminizing/masculinizing hormones or surgery; rather, these concerns need to be optimally managed prior to, or concurrent with, treatment of gender dysphoria.'*

145. The Tribunal therefore finds that those assessing the health needs of transgender persons must be competent to recognise reactive anxiety and depression arising from minority stress and to treat it or make necessary referrals to specialists. The Tribunal finds that GPs are very well placed to do so.

146. This finding is consistent with the NHS document Guidance for GPS, Other Clinicians and Health Professionals on the Care of Gender Variant People published in May 2008. Under a section titled Assessment, the guidance states:

> *'The assessment may be carried out by the GP if he or she feels competent to undertake it. If not, then the GP should refer the service user to a local mental health or gender specialist.'*

147. The Royal College of Psychiatrist publication, Good practice guidelines for the assessment and treatment of adults with gender dysphoria (2013) states:

> *'Primary care continues to be central to the delivery of medical and psychological care to the majority of patients. It is desirable for a single practitioner to adopt the lead role to facilitate coordinated care. General practitioners are likely to undertake this role.'*

This guidance thereby acknowledges that GPs are competent to deliver psychological care to transgender patients, at least as far as adults are concerned.

148. The GMC experts, Drs Q, S and T, were asked to opine on the competence of a GP to diagnose and treat, or refer for treatment, anxiety and depression in adolescents arising from minority stress. None of these experts expressed a view that GPs lack the competence to diagnose, treat, or refer for treatment, anxiety and depression in arising as a reaction to minority stress.

149. Drs Q and S were asked by the GMC to review the medical records of Patients A, B and C. Dr T was not asked to do likewise.

150. The Tribunal notes that Dr S's expertise in transgender healthcare has been acquired in the adult setting. He has never treated transgender adolescents. The Tribunal further notes that Dr Q has never practised in transgender healthcare.

151. Dr S stated: *'As a GP, Dr Webberley should be competent in diagnosing and treating the ordinary problems of children and adolescents. GPs are not trained in childhood and adolescent developmental psychopathology. Unless she had completed additional training in this field, she was not appropriately qualified to manage any aspect of Patient [A's] care for gender dysphoria but only diagnose the ordinary problems of childhood.'* Dr S repeated verbatim the same opinion in respect of Patient B and Patient C.

152. The Tribunal finds Dr S's opinion here to be inconsistent with his oral evidence that *'being transgender diverse isn't a disorder, that it isn't a mental health condition, that gender diverse people may experience mental health, common mental health problems more frequently than the general population, but that is not inherent in them being gender diverse'*. If GPs are competent in diagnosing and treating the ordinary problems of children and adolescents and if transgender persons may experience common mental health problems, then it follows syllogistically that GPs are competent to diagnose and treat the mental health problems of children and adolescents with gender dysphoria. The Tribunal considers that the word 'treat' in this context might include the prescription of an intervention and/or the referral of the patient to specialist services, such as CAMHS.

153. Dr Q's report in respect of Patient A states: *'There was a failure to provide the expected MDT approach and psychological assessment needed to confirm a diagnosis of gender dysphoria.'* In arriving at that opinion, Dr Q apparently disregarded the fact that Patient A had already received a diagnosis of gender dysphoria at GIDS and that GIDS would not have prescribed GnRHa medication if there had been any doubt about the diagnosis, as per the evidence of Professor F. Dr Webberley had the GIDS diagnostic assessment report at her disposal when Patient A presented to her. Dr U stated:

> *'I do not fault Dr Webberley for not having Patient A re-evaluated by a mental health professional after the diagnosis of GIDS [gender identity disorder] had been previously made and her own assessment corroborated the diagnosis.'*

154. The Tribunal finds on the evidence before it that there was no need to make a diagnosis afresh. It also finds that the depression and anxiety Patient A was experiencing when he saw Dr Webberley in March 2016 was self-evidently a reaction to his profound and lifelong gender dysphoria coupled with the bleak prospect of being suspended by GIDS in a peripubertal state for four and a half years while XXX and peers progressed through puberty. This was the inescapable conclusion reached by the Tribunal having read the statements and heard the compelling evidence of Patient A and his mother. The Tribunal finds that any GP, let alone a GP such as Dr Webberley with a special interest in gender dysphoria, would be competent to recognise the reactive nature of the anxiety and depression Patient A was evincing at the material time. The cause of Patient A's anxiety and depression was, in the

Tribunal's view, as plain as a pikestaff: it was the decision by GIDS to withhold gender-affirming therapy until he was sixteen years of age.

155. Dr Q's report in respect of Patient B is explored below in respect of the potential neurodevelopmental issues that this case raised.

156. Dr Q's report in respect of Patient C states:

> *'The psychology input did not fully explore differential/co-morbid diagnoses (e.g. ADHD) indicated by Patient C's mother's developmental history and background in in-utero exposure to heroine. Screening measures or multidisciplinary assessment should have been used to ascertain the need for further investigation. No referral was made to explore a diagnosis of ADHD.'*

The Tribunal noted Dr Q's opinion. In fact, Dr Webberley did refer Patient C to an appropriate specialist, namely Dr V, an HCPC – registered Psychologist / Chartered Psychologist and Gender Specialist, although she did not record the terms of that referral. Dr V examined Patient C twice and provided a report [C4/191]. Dr V stated in her report:

> *'Across the course of three hours of discussion/assessment with me, Patient C was polite, attentive and patient. He was engaged throughout, took turns speaking with others present, and showed a reasonable degree of concentration. From this perspective, a diagnosis of ADHD does not seem pressing, though his parents may wish to pursue ADHD-specific assessment.'*

157. Dr V therefore provided a reassuring opinion to Dr Webberley in respect of ADHD. The Tribunal will consider whether in fact this opinion addressed the WPATHSOC7 recommendations under the relevant paragraph of the Allegation. Whether or not it did, the fact of the referral appears to evidence Dr Webberley's competence to detect or recognise potential neurodevelopment conditions, to make appropriate referrals and to incorporate the input of specialists into her practice.

158. The Tribunal also had regard to the expert opinions of Drs V, U and W.

159. Dr V's stated:

> *'With respect to question whether a GP is able to diagnose and treat gender dysphoria, clinical guidance indicates that proficiency may be obtained via various sources. To date, and in 2016/17, there is no degree course specific to diagnosis and treatment. As with other conditions in the ICD and DSM, basic clinical training is the basis and further specialist engagement follows. GPs can adequately gain the skills and knowledge required to assess and diagnose gender dysphoria through personal learning, attendance at conferences and discussion with colleagues. Continued professional development and membership to specialist organisations are a key part on maintaining standards.'*

160. Commenting on Dr Webberley specifically, Dr V stated: *'Dr Helen Webberley is very highly trained and competent in the domain of transgender healthcare.'* The Tribunal noted that Dr V has met and worked alongside Dr Webberley, whereas the GMC experts have not.

161. Dr U stated: *'In reviewing Dr Webberley's training and experience, the management of gender dysphoria does not appear to be beyond her limits of competence. It is my strong opinion that the fact that she is a GP should not exclude her from providing gender affirming care given her training and experience in this field.'*

162. The Tribunal accepts that Dr U has not met Dr Webberley and that he is an endocrinologist and therefore perhaps not well placed to comment on Dr Webberley's competence to diagnose and assess mental ill health. The same most certainly cannot be said of Dr W, who is not only an eminent psychiatrist with many years of experience in transgender healthcare, but also the current President of WPATH, the very organisation that GIDS looks to for guidance.

163. Dr W reviewed Dr Webberley's care of Patients A, B and C and stated in each report:

> *'In my opinion, Dr Helen Webberley is a specialist in trans healthcare as evidenced by her medical training, her clinical experience, her long involvement with various trans communities, including young trans people and their families (of choice), her continuous professional education, and her many years of clinical practice in transgender health, including the prescription, dosing and monitoring of gender affirming hormone treatment.'*

164. The Tribunal therefore finds that GPs are competent to recognise and treat, or refer onwards for specialist treatment, persons with mental ill health arising as a reaction to minority stress. Dr Webberley, as an experienced GP and as a doctor with a special interest in transgender healthcare, was most certainly competent in those respects.

165. The Tribunal next addressed itself to the question of whether Dr Webberley had the competence to recognise neurodevelopmental conditions, to make the appropriate assessment referrals for patients with suspected neurodevelopmental conditions, and to incorporate the findings of such assessments into the soliciting and eliciting of informed consent.

166. The Tribunal did so because it received evidence that Patient B's capacity to consent to treatment may have been compromised by an unconfirmed 'diagnosis' of autistic spectrum disorder (ASD) and that Patient C's capacity to consent to treatment may have been compromised by traits that his mother felt might suggest attention deficit hyperactivity disorder (ADHD).

167. The Tribunal received evidence that ASD is overrepresented in the gender dysphoric population. For example, WPATHSOC7 states that *'The prevalence of autism spectrum*

disorders seems to be higher in clinically referred, gender dysphoric children than in the general population.' Published estimates of the prevalence of ASD in those referred to gender identity clinics vary from 9% to 26%.

168. Given the potentially irreversible effects of gender-affirming hormone (stage-2) treatments, such as loss of fertility, valid consent is clearly a profoundly important issue in transgender healthcare. The high rates of ASD in the gender dysphoric population make the ability to recognise cognitive impairment an important competency for practitioners in transgender healthcare.

169. The Tribunal notes that Patient B had a possible 'diagnosis' of ASD, but that he had declined to undergo an ASD assessment at his local CAMHS in August 2015. He and both his parents signed Dr Webberley's consent form in September 2016. Dr Q's report in respect of Patient B states:

> *'There was a failure to provide the MDT input expected by WPATH for gender dysphoria. There was a failure to incorporate and [sic] MDT approach for other mental health and neurodevelopmental issues. This was an inadequate standard of MDT care.'*

170. Dr Q did not opine that Dr Webberley was not competent to recognise ASD and to take it into account in her assessment of a patient's capacity to consent to treatment, nor did he explain how an 'MDT approach' would have altered the care plan necessary to meet Patient B's needs.

171. Patient C presented with dyslexia and a parental concern that he might have ADHD alongside his gender dysphoria. Dr Webberley referred Patient C to Dr V, a Chartered Consultant Psychologist and Gender Specialist, for assessment. Dr S in his report opines:

> *'If Dr HW had not identified Dr V as an appropriately qualified and experienced specialist, this would have fallen seriously below the standard expected of a reasonably competent General Practitioner with a special interest in gender care and sexual health.'*

The Tribunal finds Dr S's opinion here to be unhelpful. Dr Webberley did refer Patient C to an appropriate specialist and the Tribunal finds that this evidences Dr Webberley's competence to detect or recognise potential neurodevelopment conditions, to make appropriate referrals and to take into account reports from specialists when assessing a patient's capacity to consent.

172. Dr Webberley was asked by the Tribunal about the skills GPs have in recognising neurodevelopment conditions. She stated:

> *'I think what is important, and I think most GPs would agree, is that if a mum brings their child to you saying 'School or social group or friends have been expressing*

concern that my child might have ADHD or might be on the autistic spectrum', then GPs are faced with that very often and will make an initial assessment as to whether an onward referral for an assessment in terms of statementing for school, or what have you, was necessary. So I think that all GPs over the last decade have increased their skills in knowing that area.'

173. The Tribunal accepts Dr Webberley's evidence that GPs have the competence necessary to recognise potential neurodevelopmental issues when assessing their patients.

Dr Webberley's Competence as a Hormone Prescriber

174. The Tribunal received evidence concerning the nature of the hormones Dr Webberley prescribed to Patients A, B and C.

175. GnRHa is a synthetic analogue of gonadotropin-releasing hormone (GnRH). GnRHa blocks the action of natural GnRH and has been used 'for decades' to suspend puberty in persons presenting with early onset, so-called 'precocious', puberty. The use of GnRHa to suspend puberty in transgender adolescents was pioneered in the Netherlands in the 1990s.

176. Testosterone is a sex steroid hormone. It is naturally produced in males (XY) during puberty when it induces secondary sexual characteristics, a process referred to as masculinisation. Hypogonadal children are deficient in endogenous sex steroid hormones and, as a result, experience delayed onset puberty. Sex steroids are routinely administered as a hormone replacement therapy in the treatment of hypogonadism. Testosterone was isolated in 1935 and reports of its use as a gender-affirming hormone to treat gender dysphoric transmen first appeared from the mid-twentieth century.

177. Administration of GnRHa and testosterone to ameliorate the distress caused by gender dysphoria was therefore hardly at the frontier of medicine when Dr Webberley treated patients A, B and C in 2016/17. On the contrary, hormone therapy was already a long-established treatment modality in transgender healthcare by that time. What was changing was the age of transgender patients to whom these hormones were being administered, and the Tribunal explores that point below.

178. The abovementioned body of longstanding experience has led to the view that gender-affirming hormones are safe medications for use in transgender healthcare. Thus, Endocrine Society Guidelines 2009 states: *'Cross-sex hormone therapy confers the same risks associated with sex hormone replacement therapy in biological males and females.'* Endocrine Society Guidelines 2009 goes on to explain that the risks of 'cross-sex' hormones are those associated with over-dosage or under-dosage. Provided gender-affirming hormones are used at physiological doses to maintain normal physiology, they are safe.

179. Dr P confirmed that testosterone is a safe agent when administered to adolescents to induce a cisgender puberty, but he stated that there is insufficient evidence concerning the safety of testosterone when used to induce a transgender puberty in adolescents.

180. Professor F was more emphatic. He stated that the NHSE Clinical Commissioning Policy, into which he had 'considerable input', found that there was no evidence of using testosterone to induce transgender puberty in persons below the age of sixteen.

181. There is, in fact, evidence relating to the safety of testosterone to induce puberty in transmen at the age when puberty naturally occurs, i.e. during a person's adolescence, which typically begins at around twelve years of age in males. Dr X was the principal investigator on a study that included thirteen patients below the age of sixteen and reported no adverse outcomes. This observational study was known to Dr Webberley in early 2016, even though Dr X's research was not published in its final form until 2018.

182. Dr P revealed under cross-examination that he had treated a transgender adolescent aged thirteen with gender-affirming hormones and that he was aware of centres elsewhere that treat transgender adolescents from the age of fourteen.

183. The GMC's academic research bundle cited a retrospective study published in 2017 in which transgender adolescents received gender-affirming therapy between 2008 and 2014. The ages of patients reported in that study were 13 to 22 (transmen) and 14 to 25 (transwomen).

184. There is, therefore, a body of evidence relating to the use of sex steroids to treat gender dysphoria in adolescent transgender persons. This has led to a 'stage-not-age' view of when administration of sex steroids is clinically indicated: some experts, such as Dr U, now deem that it is the pubertal stage of the patient that matters, not their chronological age.

185. Dr X, a world renowned gender specialist, referred to Endocrine Society Guidelines 2017 which, unlike Endocrine Society Guidelines 2009, does not mandate the age of 16 as an eligibility criterion for the prescription of gender-affirming hormones. She stated:

> *'Other professional guidelines are now acknowledging the importance of individualized care plans over protocols as appropriate and critical when working with gender diverse youth. This is in keeping with the recognition of historical harms perpetuated among gender and sexual minority communities by the medical community itself, including its history of gatekeeping and subjective prerequisites for access to care.'*

186. Dr P was specifically asked by the Tribunal whether, given the established safety record of sex steroids in the induction of puberty in hypogonadal cisgender adolescents, there was any reason to suspect that sex steroids might be unsafe in the transgender adolescent context. His answer was:

> *'Yes, but I think it is the same ... Let me put it … I would not be a good doctor if I thought I would be practising unsafe medicine. So the consensus is that is a safe procedure, trying to draw analogues, like you correctly said, with the cisgender*

population. But there are some differences of course because you know the genetic make-up is different from those from the cisgender population, the timing of the start of the gender-affirming hormones is different if you experience a full puberty or not on your own or ... So there are certain elements that makes it different from the cisgender studies and that prompts us to be careful and take good clinical procedures to really balance all those factors out to make a good - to make a sound decision to start treatment or not. But as we have not known until now, there aren't really big, big medical concerns reported at this point with the safety of gender-affirming hormones in adolescent youths.'

187. The Tribunal found Dr P's answer to this question to be largely inscrutable, but he appeared to convey that in his expert opinion there are no reasons to suspect that administration of sex steroids to induce puberty in a transgender adolescent would be less safe than the administration of sex steroids to induced puberty in a cisgender adolescent.

188. The Endocrine Society Guidelines 2009 were updated in 2017 and reflected the evolving view in respect of the age at which gender-affirming hormones might be safely prescribed. Endocrine Society Guidelines 2017 states:

'We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years.'

189. The Tribunal notes that the phrase 'minimal published studies', is rather at odds with Professor F's assertion that there are no such studies. The Tribunal accepts that 2017 was after Dr Webberley provided care to patients A, B and C, but it also notes that trends in medicine are generally discussed at meetings and within professional networks long before they mature into final published form. WPATHSOC7 and ICD11 exemplify this point.

190. The Tribunal therefore concludes that the safety of administering sex steroids to adolescents in the cisgender context was well established at the material time. Published evidence relating to the safety of administering sex steroids to adolescents in the transgender context was limited, but there is no basis to suggest that it would be unsafe and there was evidence, albeit limited, that it is safe.

191. The Tribunal now turns to the question of who is qualified to be a hormone prescriber.

192. The Tribunal has already noted that Endocrine Society Guidelines 2009, which is guidance produced by endocrinologists for endocrinologists and published in the Endocrine Society's house journal, did not stipulate that the hormone prescriber providing treatment to persons with gender dysphoria need necessarily be an endocrinologist. Similarly, the Tribunal has cited WPATHSOC7 as stating:

> *'With appropriate training, feminizing/masculinizing hormone therapy can be managed by a variety of providers, including nurse practitioners, physician assistants, and primary care physicians'*.

193. NHS guidance to GPs published in 2008 stated: *'GPs are usually at the centre of treatment for trans people, often in a shared care arrangement with other clinicians. GPs may prescribe hormones and make referrals to other clinicians or services, depending on the needs of the particular service user. Sometimes a GP has, or may develop, a special interest in gender treatment and may be able to initiate treatment, making such local referrals as necessary.'*

194. A bulletin issued by the International Planned Parenthood Federation in 2015 stated:

> *'Physicians who provide hormone therapy do not usually receive specific training, and standard certification for this care does not exist. Throughout the world, hormone therapy for transgender adults is provided by physicians from different specialties, including endocrinology, family medicine, internal medicine, obstetrics and gynaecology, and psychiatry.'*

195. The Tribunal noted from the evidence of Dr U that 'family medicine' is a term used in some countries to mean what in the UK would be referred to as general practice.

196. The competence of GPs to prescribe gender-affirming hormone therapy was endorsed in 2016 by the GMC, when the then Acting Chief Executive wrote to the Chair of the British Medical Association's GP Committee stating:

> *'… we don't believe that providing care for patients with gender dysphoria is a highly specialist treatment area requiring specific expertise. This is particularly the case once the patient has been seen by a gender specialist who has recommended or requested that prescribing and monitoring of hormone therapy be carried out in primary care.'*

197. It is therefore apparent that in the mid-2010s the GMC, the NHS and professional associations around the world were promoting the involvement of GPs in transgender healthcare services. WPATHSOC7 and Endocrine Society Guidelines 2009 did not preclude GPs from being hormone prescribers.

198. The evidence before the Tribunal is that Dr Webberley was, at the material time, a gender specialist. Indeed, the allegation against Dr Webberley is predicated on the GMC's acceptance that Dr Webberley was, in fact, at the material time, a General Practitioner with a special interest in gender dysphoria.

199. The Tribunal has already noted that Dr Webberley obtained a diploma in psychosexual medicine in 2002, that she undertook career grade training in sexual and reproductive health in 2006 and that she attained membership of the Faculty of Reproductive and Sexual Health in 2007. Dr Webberley was, therefore, a GP with a special

interest in sexual health. The Tribunal finds this particularly relevant, given the reclassification of gender dysphoria from a mental illness (ICD10 and DSM-4) to a somatic condition related to sexual health (ICD11).

200. Dr Webberley's evidence was: *'I additionally gained the diplomas of Psychosexual Medicine and of Genitourinary Medicine, and I worked in specialist Sexual Health clinics where I gained considerable experience and knowledge of sex hormones.'*

201. She further stated: *'As GPs, we are daily and continually assessing and treating patients with mental illness, and with hormonal needs such as contraception, female HRT and male testosterone replacement therapy. Thus, we are well-versed to the indications, cautions, contraindications and posology of such treatments.'*

202. Dr Webberley explained:

> *'The medicines used in this field [gender dysphoria] are ones that I was well used to prescribing in General Practice and in my Sexual Health Clinics. The puberty blockers, GnRH Agonists, are used to suppress hormone production in people with prostate cancer and people undergoing fertility treatment, or people with endometriosis and children with precocious (early) puberty. I am very used to prescribing testosterone to people who have low testosterone levels, and oestrogen to those with low oestrogen levels.'*

203. The Tribunal found Dr Webberley to be an impressive witness. She answered technical questions about hormone therapies unhesitatingly and authoritatively. Whilst this Tribunal is not itself qualified to assess Dr Webberley's competence in hormone therapies, the Tribunal was impressed by the depth and breadth of her knowledge of endocrinology and gender dysphoria. The Tribunal was in no doubt that Dr Webberley had immersed herself in the field of transgender healthcare to the extent that she could properly be described as a GP with special interest in gender dysphoria, both in respect of the psychosocial and the endocrine facets of this field of medical practice.

204. The Tribunal does not ignore the point that administering hormone replacement therapy to a middle-aged menopausal woman or to a middle-aged man experiencing the 'male menopause' or to an adolescent with hypogonadism or that the arresting of precocious puberty are different clinical scenarios to the induction of puberty in a transgender adolescent; however, the Tribunal accepted Dr Webberley's persuasive evidence that there are significant overlaps. She explained that administration of GnRHa medically induces a state that mimics hypogonadism, a condition with which she is familiar, and the information Dr Webberley provided to GPs when seeking to enter into shared care agreements makes reference to the potential for testosterone therapy to induce erythrocytosis and thrombophilia in transmen in the same way as when it is used in cisgender males:

> *'It is anticipated that trans men (like hypogonadal cis gender men) will remain on lifelong hormone replacement therapy with testosterone. The goal is to avoid*

hypogonadism while reducing the potential impact of any negative effects of testosterone, the most serious of which are related to polycythaemia and erythrocytosis, and associated adverse thrombotic events.' It was precisely this kind of evidence that persuaded the Tribunal that Dr Webberley had developed an in-depth knowledge of clinical endocrinology in the context of transgender healthcare.

Alternative Models of Transgender Healthcare

205. A central plank in the GMC's case against Dr Webberley was that in providing care to Patients A, B and C Dr Webberley did not operate within a multidisciplinary team setting, as advocated in WPATHSOC7 and Endocrine Society Guidelines 2009 and as exemplified by GIDS.

206. In rebutting this criticism, Dr Webberley relied on the case of ***Bolam v Friern Hospital Management Committee [1957] 1 W.L.R. 582***. Dr Webberley's case was that her practice was *'in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art'* notwithstanding her departure from the model of care deployed at GIDS.

207. The Tribunal finds that Dr Webberley's practice was indeed in accordance with that considered proper by a responsible body of medical practitioners. It also finds that her mode of practice did involve a multidisciplinary team, albeit not one that precisely emulated the configuration at GIDS.

208. The Tribunal's analysis of Dr Webberley's decision to stray in some respects from the approach enshrined in WPATHSOC7 and Endocrine Society Guidelines 2009 necessarily begins by confronting the metaphorical elephant in the room, namely waiting times.

209. For the avoidance of doubt, the Tribunal makes clear its position that an attempt to reduce waiting times or a wish to give in to insistent demands from patients for immediate treatment can never give licence to a doctor to compromise the safety or quality of the care they provide. The Tribunal finds, however, that when an established facility is unable to cope with the demand for its services, it is incumbent on other practitioners in the sector to seek out alternative ways to help those patients in pressing need of attention but facing inordinately long waiting lists. That some patients with gender dysphoria are so desperate they are driven to suicide gives considerable impetus to this need for alternative approaches.

210. The NHS Service Specification that underpins GIDS states at paragraph 3.4.1 *'Referral management: New clients will be seen within 18 weeks from the date the referral is received.'*

211. The House of Commons Women and Equality Commission report 'Transgender Equality', published 08/12/15 found that: *'Demand for the GICs' services is growing at a significant rate, with referrals increasing by an average 25–30 per cent a year across all the clinics.'* The report goes on: *'times for initial appointments are in breach of patients' legal*

entitlement, under the NHS Constitution, to have their first appointment in a specialist service within 18 weeks of referral.'

212. The House of Commons Women and Equality Commission considered evidence relating to all the NHS GICs, not just the GIDS, and therefore covered services for adults, as well as those for children and adolescents, but the waiting times at GIDS were no less concerning in the mid-2010s.

213. The NHS England Specialised Services Clinical Reference Group for Paediatric Medicine publication, 'Clinical Commissioning Policy: Prescribing of Cross-Sex Hormones as part of the Gender Identity Development Service for Children and Adolescents' stated: *'Referrals to England's designated Gender Identity Development Service for children and young people rose by 32% between 2007 and 2012 and there was an increase of 104% between 2014/15 and 2015/16.'*

214. It is therefore common ground that the demand for transgender healthcare had been increasing across all age cohorts, especially amongst young people, during the 2010s. This increased demand naturally put pressure on NHS services. The judgment in ***Bell v Tavistock [2020] EWHC 3274 (Admin)*** observed that: *'As at November 2019 the waiting time for a first assessment at GIDS was between 22–26 months.*'

215. By the time CQC inspected GIDS in October/November 2020, they concluded: *'The service was difficult to access. There were over 4600 young people on the waiting list. Young people waited over two years for their first appointment.*' Such a backlog could not occur overnight: it was evidently the culmination of a long period in which capacity could not meet demand.

216. The Tribunal therefore finds that at the material time there was immense pressure on GIDS and that some aspirant service users were, as a result, left in a state of desperation.

217. The Tribunal also received evidence that some service users found that the rigid and protocol-driven approach at GIDS did not meet their needs in terms of timeliness of interventions and that the protracted and repetitive nature of the psychological assessment phase was intrusive and overbearing. The Tribunal has set out at some length the revision in thinking that was taking place in the mid-2010s that has led to the 'de-psychopathologisation' of gender dysphoria in ICD11.

218. GIDS was, in the view of the Tribunal, commendably striving to deliver a safe and first-rate service. It is, however, an in escapable fact that a service which, on the evidence of Professor F, employs forty professionals to deliver the diagnostic and assessment element of a care pathway and highly trained endocrinologists and clinical nurse specialists to deliver hormone therapies must be costly. Replicating GIDS at other NHS trusts was one option open to NHSE to address the waiting lists, but it is hardly controversial for the Tribunal to point out that the NHS has finite resources.

219. The Tribunal received evidence from many sources that delayed treatment of gender dysphoria can be very deleterious to the wellbeing of some transgender persons and that early intervention can be advantageous when appropriate in specific cases. For example, WPATHSOC7 states:

> *'Neither puberty suppression nor allowing puberty to occur is a neutral act. On the one hand, functioning in later life can be compromised by the development of irreversible secondary sex characteristics during puberty and by years spent experiencing intense gender dysphoria.'*
>
> and:
>
> *'Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization. As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during adolescence … withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents.'*

220. The Tribunal was greatly assisted in this respect by the expert opinion of Dr T. She stated:

> *'I think early intervention is important and I think delaying intervention unnecessarily can exacerbate distress. However, I think we know that for some children who have experienced gender dysphoria something changes during that period of adolescence to the point where their gender dysphoria doesn't present. There are various theories around the relative impact of the physical puberty, of the kind of changes, of societal changes that happen during puberty or the development of sexual feelings or some combination of these. We know that for some children who present with distress about gender it will not persist, so that makes the question about early intervention a complex question and so intervention absolutely needs to be prompt, as soon as it is relatively clear that the young person's gender identity has been consistent and persistent and that they can make an informed decision about treatment.'*

221. Dr T's testimony therefore reflected evidence already alluded to by the Tribunal, namely that gender dysphoria in children is often self-remitting. The Tribunal was also mindful that gender dysphoria in adolescents typically persists and that almost all persons in this cohort will wish to progress from puberty blocking to gender-affirming hormone therapy.

222. Given the aforementioned points, it is, in the view of the Tribunal, hardly surprising that some GIDS service users, such as Patients A, B and C, sought out Dr Webberley as an alternative to GIDS. It is also the Tribunal's finding that for Dr Webberley to have replicated the GIDS care pathway in her own practice would have been absurd, given the resource-intensive nature of GIDS and the dissatisfaction expressed by some patients with the care offered to them by GIDS. The logical and proper approach in those circumstances was, in the view of the Tribunal, for Dr Webberley to seek out safe and effective alternatives to the GIDS

care pathway and in doing so to embrace the new thinking that transgenderism is not a mental illness. It is not for this Tribunal to determine whether or not GIDS was or is an effective care provider. The Tribunal merely finds that there was patently room in the sector for alternatives to GIDS in order to meet the needs of those transgender persons who were unable to secure the care they needed from GIDS.

223. Dr Webberley explained that in developing her transgender practice, she was assisted by guidance published by the Center of Excellence for Transgender Health, Department of Family & Community Medicine University of California, San Francisco (the UCSF guidelines). This guidance had its origins in a feature article published in 2014 and was formulated into a care manual in 2016. Unlike WPATH7 and Endocrine Society Guidelines 2009, the UCSF guidelines were the product of a single centre, but the chapters were written by twenty-four experts from several institutions in the USA. The Tribunal finds that the UCSF guidelines had the status of peer-reviewed expert guidance. It was, in other words, 'the practice accepted as proper by a responsible body of medical men skilled in that particular art'.

224. The UCSF guidelines are an exemplar of what has become known as the informed consent model (ICM) of transgender care.

225. WPATHSOC7 provides a helpful explanation of how the ICM compares with the WPATH approach:

> '*A number of community health centers in the United States have developed protocols for providing hormone therapy based on an approach that has become known as the Informed Consent Model (Callen Lorde Community Health Center; Fenway Community Health Transgender Health Program, Tom Waddell Health Center). These protocols are consistent with the guidelines presented in the WPATH Standards of Care, Version 7. The SOC are flexible clinical guidelines; they allow for tailoring of interventions to the needs of the individual receiving services and for tailoring of protocols to the approach and setting in which these services are provided.'*

> WPATHSOC7 further states:

> *'The difference between the Informed Consent Model and SOC, Version 7, is that the SOC puts greater emphasis on the important role that mental health professionals can play in alleviating gender dysphoria and facilitating changes in gender role and psychosocial adjustment. This may include a comprehensive mental health assessment and psychotherapy, when indicated. In the Informed Consent Model, the focus is on obtaining informed consent as the threshold for the initiation of hormone therapy in a multidisciplinary, harm-reduction environment. Less emphasis is placed on the provision of mental health care until the patient requests it, unless significant mental health concerns are identified that would need to be addressed before hormone prescription.'*

226. The ICM is therefore not a radical departure from WPATHSOC7. The key difference is that the ICM dispenses with the gate-keeper role of the mental health professional and in doing so embraces the view that evolved in the 2010s that gender dysphoria is not a mental illness.

227. The ICM also places the GP (family therapist, primary care provider) at the centre of the care pathway.

228. The concept of GPs acting as gender specialists in a hub-and-spoke configuration of care delivery was envisaged in the NHS 2013/14 Interim Gender Dysphoria Protocol and Service Guideline. It stated:

> *'NHS England may commission a specialised Gender Identity Clinic (GIC) service from providers able to deliver the range of multidisciplinary services described in this document, and offer effective and high-quality care for gender dysphoria. Historically, such services have been single-centre, consultant-led, multidisciplinary teams but other models, for example multi-centre, multidisciplinary clinical networks involving General Practitioners with special interest in gender dysphoria, are not excluded.'*

229. Dr U, a paediatric endocrinologist, opined that GPs are better placed than endocrinologists to care for transgender persons, as it is part and parcel of GPs' training to take a holistic approach to their patients. He stated:

> *'In the future, I expect the location of care for gender dysphoria in the pediatric population to continue to move from tertiary clinics to primary care clinics, as gender dysphoria is not a rare condition and medical education is now covering gender dysphoria in detail to trainees eager to become competent in management of this condition.'*

230. He also made the pithy observation

> *'… if gender care was confined only to pediatric endocrinology, the demand for services would quickly outpace the supply of services, which appears to have happened in the UK with seeming resistance to expanding the pool of providers.'*

231. The 'Trans Care Project' in Vancouver, Canada, is another exemplar of the ICM model of transgender healthcare, but in a primary care setting. When the city's hospital gender dysphoria programme was closed in 2002, a decentralised community-based model of care was set up in its place. Care for the transgender population became the responsibility of community-based clinicians with varying degrees of transgender training and experience.

232. The 2008 NHS publication, 'Guidance for GPs, other clinicians and health professionals on the care of gender variant people', contains a visionary comment: *'We herald a new approach to care which has evolved from a linear progressive sequence to multiple pathways of care which recognise the great diversity of clinical and presentation*

needs.' The same NHS publication states *'The role of 'gate-keeper' (the health professional who has the capacity to prevent or delay treatment) conflicts with the supportive role that is central to a health professional's relationship with a client.'*

233. The Tribunal also finds that Dr Webberley did, in fact, adopt a multidisciplinary approach to her practice. She may not have had forty colleagues in the way Professor F has at GIDS, but she had developed professional links with psychologists (Drs FF and V) and counsellors (Ms XX, Ms DD and Ms EE). The Tribunal notes that Dr Webberley is not criticised by the GMC for not having a team of speech and language therapists, occupational therapists, social workers, surgeons etc that are on offer at GIDS. The point is that Dr Webberley adopted a bespoke approach to her care of Patients A, B and C, made appropriate referrals and offered counselling. The Tribunal finds that it received no evidence that Dr Webberley's 'hub-and-spoke' approach to multidisciplinary team working was unsafe or ineffective, nor has it received any evidence that GIDS achieves better outcomes than alternative models of care such as ICM. The Tribunal finds that Dr Webberley's role as the 'hub' was analogous to that of the 'Lead Worker' specified in E13/S(HSS)/e.

234. Dr Webberley's approach might be regarded as being at the vanguard of this evolving approach to transgender care. This was certainly the opinion of Dr X in a report she submitted to the GMC in 2019.

235. Dr X is a highly reputed gender specialist. She is the Medical Director of the Center for Transyouth Health and Development at Children's Hospital Los Angeles, which is the largest transgender youth clinic in the USA with, at the time of writing her report, 'over 1500 youth in active services right now, ranging in age from 3 to 25 years.'

236. Dr X made a detailed analysis of the case notes of Patient A and, finding no fault in the care administered by Dr Webberley, stated *'The standard of care is to induce a puberty that most closely mimics that of a cisgender boy, which Dr Webberley has done.'* She further stated *'It is clear in her presentation of this case that Dr. Webberley has not only considered and practiced with the aforementioned elements of conscientious gender affirming care, but has gone above and beyond'* and *'Her work, and the work of Gender GP should be acknowledged as insightful, future forward and critical for this population of vulnerable youth.'*

Conclusions

237. Dr Webberley was at the material time a GP with a special interest in gender dysphoria and she was competent in the roles of mental health professional and hormone prescriber. Dr Webberley adopted a hub-and-spoke approach to her care for Patients A, B and C, referring them to specialists if and when required. She was competent to determine when such referrals were necessary. Dr Webberley was not bound to follow precisely the

WPATHSOC7 or Endocrine Society Guidelines 2009 guidelines, although she did avail herself of the guidance therein. She was at liberty as an autonomous medical practitioner to look to alternative guidance and did so. Her reliance on the UCSF Guidelines was in accordance with a responsible body of expert medical opinion.

The Tribunal's Findings

Patient A

Paragraph 1

1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

   a. obtain an adequate medical history for Patient A, in that you failed to elicit information about:

      i. Patient A's physical or psychosocial childhood;

      ii. adolescent development;

      iii. gender identification and development;

      iv. any adaptions made to address gender incongruence;

      v. mental health;

      vi. self-harm or suicidal ideation and associated risk factors;

238. Paragraphs 1(a)(i)– (vi) are considered together.

239. In his report dated 19 March 2021, when asked about the adequacy of the medical history taken in relation to Patient A, Dr S stated:

> *'The response contains no information about Patient [A]'s physical or psychosocial childhood and adolescent development, gender identification and development, any adaptations made to address gender incongruence, mental health, learning difficulties, forensic history, substance use or history of self-harm suicidal ideation and associated risk factors.'*

240. In Patient A's medical records from GIDS, there is an 'Assessment Report' produced by two *'Highly Specialist Family Therapists'*. This report covers in detail all aspects of Patient A's family history, his relationship with members of his family, their support for him wanting to transition, his education, the involvement of other agencies including CAMHS, and other

associated difficulties, and his identification with wanting to be a male. Under the heading 'Assessment Work Undertaken', the therapists stated:

> *'the assessment aimed to understand Patient A's development and gender dysphoria in the context of his family's background and experiences'*.

241. Dr Webberley in her oral evidence said she had sight of this report some time before the face-to-face consultation with Patient A on 22 March 2016. She told the Tribunal that she went through the report with Patient A and his mother and discussed the matters set out in it, which included Patient A's psychosocial issues, childhood issues, gender identification and development and mental health. Further to the face-to-face consultation, Dr Webberley said she had consulted with Patient A and his mother through email correspondence and questionnaires. The Tribunal noted that in the Assessment Report under the heading 'Involvement of Other Agencies', it is stated:

> *'The CAMHS assessment found no evidence of mental health difficulties other than those related to his gender identity development.'*

242. In their evidence, Patient A and his mother confirmed this. They told the Tribunal that during the consultation, which lasted around one hour, Dr Webberley was very thorough and went through all aspects, and that they were both involved fully in the consultation with Dr Webberley. The Tribunal noted that in her email dated 8 February 2016 to Dr Webberley, Patient A's mother included a number of links to 'jpeg' attachments. Although the Tribunal was unable to access these links, Dr Webberley was able to see them at the time. In her oral evidence, Patient A's mother said that these were photographs of Patient A.

243. Further, in paragraph 9 of her witness statement dated 27 July 2021, Patient A's mother stated:

> *'Dr Webberley offered [Patient A] the support of mental health professionals which included counsellors, but I made clear that she did not need to make any more arrangements for Patient A to be seen by such mental health professionals, as he had been previously seen by CAMHS and was seeing counsellors at school and we had everything in place. Patient A chose not to go ahead with Dr Webberley's offer of support by mental health professionals. There was no need for a further psychological assessment to confirm Patient A's gender identity. This assessment was carried out at the Tavistock and I provided this to Dr Webberley.'*

244. The Tribunal finds that in concluding that Dr Webberley did not obtain an adequate medical history for Patient A, Dr S has focussed on the consultation of 22 March 2016. He did not take into account that Dr Webberley had available to her the comprehensive medical records from GIDS. In the Tribunal's view this was a sufficient medical history. The Tribunal was therefore not satisfied that Dr Webberley did not provide good clinical care to Patient A following the consultation on 22 March 2016 by failing to obtain an adequate medical history. It therefore finds paragraphs 1(a)(i – vi) of the Allegation not proved.

Paragraph 1

1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

b. arrange for Patient A to be **adequately** examined prior to prescribing testosterone treatment, including:
Amended under Rule 17(6)

i. a physical examination to determine:

1. blood pressure;

245. In her witness statement dated 9 August 2021, Dr Webberley stated:

'I obtain blood pressure readings in one of three ways, from a verbal account from a recent reading from the patient, from a physical reading, or from a report from another doctor. In the questionnaire on [pages 11-13/C4a], and on the UCLH clinic letter given to me by Mum [page 83/C4a], the blood pressure was not taken nor provided. Blood pressure was not provided at his UCLH clinic letter or in response to his questionnaire, however Patient A had no medical problems and was 12 years old. The treatment with blockers or hormones would not be affected by blood pressure, and blood pressure would not have altered the management plan and is not affected by treatment.'

246. The Tribunal has found several references where it is stated that blood pressure should be considered or taken prior to prescribing testosterone:

- At paragraph D11.2 of the document entitled 'Guidance for GPs, other clinicians and health professionals on the care of gender variant people' dated 10 March 2008 under the heading 'Monitoring suggestions' it is stated:

'Baseline: initially, record weight, height, blood pressure and urine tests; full blood count; liver and renal function; lipid profile; thyroid-stimulating hormone; prolactin; fasting glucose; luteinising hormone; follicle-stimulating hormone; oestradiol and testosterone; and clotting screen'

- In the Endocrine Society Guidelines 2009 on the Treatment of Transsexuals J Clin Endocrinol Metab, September 2009' at paragraph 4.1 headed 'Evidence', it is stated:

'Pretreatment screening and appropriate regular medical monitoring is recommended for both FTM and MTF transsexual persons during the endocrine transition and periodically thereafter (13, 97). Monitoring of weight and blood pressure, directed

physical exams, routine health questions focused on risk factors and medications, complete blood counts, renal and liver function, lipid and glucose metabolism should be carried out.'

- In the same document under 'Risk Assessment and Modification for Initiating Hormone Therapy', it is stated:

'All assessments should include a thorough physical exam, including weight, height, and blood pressure.'

247. Notwithstanding Dr Webberley's position, the Tribunal was satisfied that she did have an obligation to arrange for a physical examination of Patient A to ascertain his blood pressure before prescribing testosterone. She did not do this. The Tribunal therefore finds paragraph 1(b)(i)(1) of the Allegation proved.

1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

b. arrange for Patient A to be **adequately** examined prior to prescribing testosterone treatment, including:
Amended under Rule 17(6)

i. a physical examination to determine:

2. weight development;

248. The Tribunal received evidence that masculinisation causes weight gain and that body weight before and after testosterone administration is therefore a useful parameter in the monitoring of testosterone therapy.

249. Patient A's mother notified Dr Webberley in an email dated 16 February 2016 that Patient A's weight was *"6st 9¾".*

250. The question for the Tribunal was therefore whether a weight measurement in February 2016 was a satisfactory baseline for a patient starting testosterone therapy in April 2016.

251. The GMC provided no evidence, expert or otherwise, to persuade the Tribunal that the two month interval rendered the weight measurement of February 2016 unsatisfactory as a baseline.

252. The Tribunal accepts that young persons can grow rapidly, but Patient A was undergoing puberty suppression at the material time, which would reduce the likelihood of a puberty-related growth spurt between February and April 2016.

253. In these circumstances, the Tribunal was not satisfied that Dr Webberley had an obligation to arrange for a further physical examination of Patient A to ascertain his weight before prescribing testosterone. The Tribunal therefore finds paragraph 1(b)(i)(2) of the Allegation not proved.

> 1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:
>
> > b. arrange for Patient A to be **adequately** examined prior to prescribing testosterone treatment, including:
> > **Amended under Rule 17(6)**
> >
> > > i. a physical examination to determine:
> > >
> > > > 3. final height assessment;

254. The GMC relied on the evidence of Dr P as set out in his report. He stated:

> *'Somatic and/or endocrine factors that weigh in to decide the timing of starting GAH may be concerns regards 1) final height, clinically reflected in either progressively decreasing height velocity or rapid maturation of the bone age despite GnRHa treatment…'*

255. The GMC also relied on the evidence of Dr S, that despite Dr S having declared *'As I do not provide care for children and young people (aged younger than 17 years) affected by gender identity-related concerns and have no training, qualifications or experience in Paediatric Endocrinology, I cannot answer this question because it falls outside my expertise.'* Moreover, Dr S's only reference to height in his report was 'NHS England's Service Specification 1719: Gender Identity Services for Adults (Non-Surgical Interventions)' which states, *'Physical examination, other than the measurement of height, weight and blood pressure, must not be performed routinely during the assessment process.'*

256. The Tribunal received evidence that masculinisation causes increased stature and that final height attainment is an important factor in many patient's aspirations.

257. It is alleged that Dr Webberley failed to 'arrange for Patient A to be adequately examined prior to prescribing testosterone treatment, including: … final height assessment.'

258. The Tribunal found it difficult to understand how Dr Webberley could have arranged for Patient A to be examined prior to prescribing testosterone for final height, when final height is self-evidently attained after treatment. The only height measurement that Dr Webberley could feasibly have arranged prior to prescribing testosterone was a baseline height measurement.

259. Patient A's mother notified Dr Webberley in an email dated 16 February 2016 that Patient A's height was *'5ft 1inch'*.

260. The question for the Tribunal was therefore whether a height measurement in February 2016 was a satisfactory baseline for a patient starting testosterone therapy in April 2016.

261. The GMC provided no evidence, expert or otherwise, to persuade the Tribunal that the two month interval rendered the baseline height measurement of April 2016 unsatisfactory as a baseline.

262. The Tribunal accepts that young persons can grow rapidly, but, as already noted, Patient A was undergoing puberty suppression at the material time, which would make a pubertal- growth spurt between February and April 2016 unlikely.

263. Turning then to post-treatment height measurements, the Tribunal notes that in September 2016, Patient A was again under the care of Professor F at GIDS. There was no evidence before the Tribunal that Dr Webberley had not intended to monitor Patient A's height post therapy had he still been under her care.

264. In these circumstances, the Tribunal was not satisfied that Dr Webberley had an obligation to arrange for a further physical examination of Patient A to ascertain his height before prescribing testosterone. The Tribunal therefore finds paragraph 1(b)(i)(3) of the Allegation not proved.

> 1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:
>
> > b. arrange for Patient A to be **adequately** examined prior to prescribing testosterone treatment, including:
> > **Amended under Rule 17(6)**
> >
> > > i. a physical examination to determine:
> > >
> > > > 4. bone health;

265. The GMC relied on the evidence of Dr P as set out in his report of 19 March 2021. He stated:

> *'Somatic and/or endocrine factors that weigh in to decide the timing of starting GAH may be concerns regards … 2) bone health i.e. decrease in bone mass as demonstrated by DXA scan and …'*

266. In his letter of 16 September 2015, to Patient A's GP, Professor F stated *'Bone density today was low normal – 1.5 SD in the lumbar spine.'*

267. In her witness statement dated 9 August 2021, Dr Webberley stated:

> *'His bone health was assessed by bone mineral densitometry and provided to me by Mother in a letter from UCLH found on [page 89/C4a]. In addition to this, Patient A was a normally developed child, of normal height and weight and there was no concern with his skeletal development.'*

268. The Tribunal received evidence that bone health is assessed by a radiographic procedure called a DXA-scan. This technique involves exposing the patient to ionising radiation.

269. The Tribunal found persuasive Dr Webberley's submission that it is contrary to the Ionising Radiation (Medical Exposure) Regulations 2000 for a patient to be subjected to ionising radiation unless it is strictly necessary.

270. The Tribunal received no evidence that a DXA-scan carried out at GIDS in September 2015 and reported as normal was not a sufficient assessment of Patient A's bone health for the purposes of initiating testosterone treatment in April 2016.

271. The Tribunal therefore finds paragraph 1(b)(i)(4) of the Allegation not proved.

> 1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:
>
> > b. arrange for Patient A to be **adequately** examined prior to prescribing testosterone treatment, including:
> > **Amended under Rule 17(6)**
> >
> > > i. a physical examination to determine:
> > >
> > > > 5. an assessment to ensure a synchronised pubertal development with peers;

272. In her witness statement of 9 August 2021, Dr Webberley explained her reasons for prescribing to Patient A – so that he could develop alongside XXX and other children in his social groups. She referenced Dr Y's publication entitled *'Approach to the Patient: Transgender Youth: Endocrine Considerations'* in which he stated:

> *'Despite the recommendation that cross-sex hormone treatment not be initiated before age 16 years, not only could delaying such treatment until that age be detrimental to bone health, but keeping someone in a prepubertal state until this age would isolate the individual further from age-matched peers, with potentially negative consequences for emotional well-being.'*

273. Dr Webberley added:

'This supports the prescription of gender-affirming hormones to allow young trans people to go through puberty at an age similar to that of their age-matched cisgender peers, which is before 16.'

274. In his report dated 19 March 2021, Dr P stated:

'Somatic and/or endocrine factors that weigh in to decide the timing of starting GAH may be concerns regards … 3) a synchronised pubertal development with peers.'

275. Essentially, both Dr Y and Dr P are saying the same thing. Dr Webberley's case is that she did take into account synchronising pubertal development with Patient A's peers. Had she not, the prospect of Patient A having to wait for four years before being prescribed gender-affirming hormones, while living alongside XXX and his peers whose puberty would continue to develop, could have had a detrimental impact on Patient A's emotional and mental wellbeing. Indeed, the Tribunal finds that Dr Webberley's treatment plan for Patient A was developed precisely to ameliorate the distress that would result from being held back developmentally while Patient A's peers progressed through adolescence.

276. Based on the evidence, the Tribunal is satisfied that Dr Webberley assessed Patient A's pubertal development to ensure synchronised pubertal development with his peers. It therefore finds paragraph 1(b)(i)(5) of the Allegation not proved.

Paragraph 1

1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

b. arrange for Patient A to be **adequately** examined prior to prescribing testosterone treatment, including:
Amended under Rule 17(6)

ii. a psychological assessment to confirm a diagnosis of gender dysphoria;

277. Patient A had been diagnosed with gender dysphoria in July 2015. In the GIDS assessment report dated July 2015, the following passages appear:

Features of Gender Dysphoria
Patient A meets the DSM V criteria for the diagnosis of gender dysphoria: he manifests a marked incongruence between his expressed gender and his primary and secondary sexual characteristics, has a strong desire to be rid of his female sex characteristics, a strong desire for male sex characteristics and a strong desire to be and to be treated

as a male. His gender dysphoria is of longstanding duration and is clearly associated with clinically significant distress.

Summary
Patient A is an 11 year old natal female who strongly Identifies as male. gender dysphoria is longstanding and persistent has socially transitioned with the support of his family, particularly his mother and is known as [Patient A] in all settings. The onset of puberty is a source of great distress to Patient A and he and his mother are keen for him to start blockers as soon as possible.

278. In September 2015, Professor F of UCLH confirmed the GIDS diagnosis and recommended GnRH analogues. They were prescribed by Dr H, Patient A's GP, at the William Brown Centre, on 1 October 2015. When Patient A consulted with Dr Webberley he was 11 years and 10 months old. He was aware that, under the GIDS protocol, he would not be permitted to commence treatment with gender affirming hormones until the age of about 16, some four and a half years later.

279. Patient A consulted with Dr Webberley on 22 March 2016. At that time she was in receipt of all the material to which the Tribunal refers in its determination in respect of paragraph 1(a) of the allegation. Following that consultation, Dr Webberley drew up a note of her consultation with Patient A on 22 March 2016 as follows:

'Lived as a boy all his life, no mental health issues at all. Fully male at home and school and play. There is no doubt in my mind that he will benefit from early testosterone treatment and is at risk of self harm, suicide and self medicating with body building steroids if he doesn't have T. Had negative experience with CAMHS as they did not have any knowledge of trans issues. Tavistoc is very expensive to get to and they keep asking for [XXX] *to go as well for genetic studies but then they let them down. Has great support from Mermaids and local LGBT society. GP Dr H very supportive but will only do what specialist says to do. Friends are all starting puberty and he is desperate to. Mum considering going to Germany to get private treatment if they can't get it here. They will book with GP to discuss future blockers and T prescriptions.'*

And wrote a draft letter to Dr H on 23 March 2016 as follows:

'Dear Dr H,

I met [Patient A] and his mother today and we had a long discussion about his future care. I understand that he has always felt that he was a boy and has never wavered from this. he has great support from his family, and his genetic father is also in agreement. He seeks and gains support from the Mermaids charity and from the local LGBT society with regular meetings and events.

He is currently under the Tavistock and has been prescribed hormone blockers which are working very well. [Patient A] is desperate to start testosterone therapy to allow

him to have a male puberty at the same time as his peers. He and his Mother have no concerns at all that this is the right thing to do. They have considered travelling outside of the UK to Germany and Boston in order to receive this medication as Tavistock are not willing to prescribe due to their protocols.

I also have concerns about the number of young transmen who are so desperate to start testosterone that they turn to foreign travel, or unsafe and illegal Internet sources to gain what they need.

The only way for [Patient A] to start testosterone treatment is for him to seek private care, and I am going to suggest that we arrange an independent psychological assessment to back up my feelings that it would be right for him to start treatment earlier than 16 / 18.

If you are in agreement, and have no concerns, would you be able to continue his blockers and testosterone prescriptions on the NHS, if I fully advise on his doses and blood monitoring and results?'

280. In the intervening period between the consultation and the prescription, Patient A's mother recounted to Dr Webberley Patient A's ongoing experience including the following:

- *29 March 2016 page 21:*

  '…This was immensely refreshing, and filled us with hope – I actually found myself fighting tears, just to be understood and treated this way, as our previous encounters with professionals have shown them to be typically droid-like and uncaring – there to do a job, and nothing more.

  When you stated that you were prepared to issue us with testosterone, it was music to my ears and a mountain lifted from our shoulders, especially as this is in the UK! The fact that we can now stop going to London and Leeds Tavistock several times a year (costing over several hundred pounds) is a monumental relief! We are attending an appointment with Dr H on Thursday, and I am hoping that after receiving your letters, he will have no qualms with issuing testosterone, but even if he proves to be obstinate, knowing you can still prescribe it, and the overall cost annually will still be less expensive that the Tavistock appointments, is a huge relief. I can honestly say that had it not been for you and [Ms AB] *from Mermaids, (two of the most wonderful people in the world!), I dread to think where we would be, as my sone simply could not have waited until he was 14. You both have changed our lives and given us something to look forward to and to live for! From the bottom of our hearts, we thank you both!'*

- *1 April 2016: '[Patient A] has been chronically depressed, though I have reassured him that if need be, we buy it private.'*

281. The Tribunal relies on its analysis of Dr Webberley's competencies as set out in the relevant preceding paragraphs of this determination. The Tribunal finds that Dr Webberley, who had a special interest in gender dysphoria, was competent to recognise that the anxiety and depression which Patient A was evincing was a reaction to his profound and lifelong gender dysphoria coupled with the bleak prospect of being suspended by GIDS in a peripubertal state for some four and a half years while XXX and peers progressed through puberty. In consequence, Dr Webberley prescribed testosterone. The Tribunal finds that Dr Webberley was under no obligation to arrange for a further psychological assessment to confirm the diagnosis of dysphoria already made.

282. The Tribunal therefore finds paragraph 1(b)(ii) of the Allegation not proved.

Paragraph 1

1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

c. prescribe clinically-indicated treatment to Patient A, in that testosterone:

i. was not appropriate for use in children of Patient A's age;

283. In considering this paragraph of the Allegation, the Tribunal has assumed that the word 'child' should be interpreted as 'adolescent' since Patient A was an adolescent when Dr Webberley prescribed testosterone for him. He had started puberty aged 11 and was at Tanner stage 2 when assessed by GIDS in July 2015, some 9 months prior to Dr Webberley prescribing testosterone.

284. The Tribunal relies on its analysis of Dr Webberley's competencies as set out in the relevant preceding paragraphs of this determination. It rejects the allegation that Dr Webberley failed to provide good clinical care to Patient A by prescribing a hormone, testosterone, which was not appropriate for use in children of his age.

285. The Tribunal therefore finds paragraph 1(c)(i) of the Allegation not proved.

Paragraph 1

1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

c. prescribe clinically-indicated treatment to Patient A, in that testosterone:

ii. was commenced without the input of an integrated multi-disciplinary team beforehand;

286. The evidence established that Dr Webberley did have a multidisciplinary team available to her when she prescribed testosterone to Patient A. In particular she had counsellors and access to Dr V and Dr SS, a general physician who had experience in endocrinology. However, whilst she had that team available to her, it also established that she sought no input from that team in respect of her assessment and decision to prescribe testosterone to Patient A, XXX. She had already made the decision to prescribe testosterone to Patient A in principle by the time she sought his advice which he provided on 25 February 2016. The reason for her seeking that advice was to review Patient A's history and obtain his opinion on a treatment strategy. Dr SS advised:

'Although our protocol has always been that we would reserve opposite sex hormones until the age of 16, this has only been based on a handful of data, and we have always been aware that this kind of scenario would arise. Furthermore, it is likely that the family would try and acquire testosterone by other routes if we are not seen to be helping.
It is my belief therefore that it would be safer for Patient A to start on low dose testosterone and at least be safely monitored. There is plenty of data to suggest that it is safe to do this and would certainly be in the interests of Patient A and his family's wishes. I think he should remain under counselling and his growth charts be monitored.'

287. Although Dr Webberley sought advice from XXX, who was not a paediatric endocrinologist, it is appropriate to note that she did not have many alternatives. The family had turned away from the obvious source of advice, namely Professor F, and there was no one else in the UK to whom she could turn in that specialty. The fact that Dr SS was XXX does not necessarily preclude him from being a source of advice – one of the experts called by the GMC worked with XXX. However, the Tribunal interpret this paragraph of the allegation as meaning she did not obtain the input from appropriately qualified members of the multidisciplinary team.

288. Dr Webberley's position in respect of this is set out in her witness statement as follows:

'Prior to treatment, I referred to the extensive and comprehensive assessment carried out by GIDS. When starting treatment, I asked my team to 'refer to Dr FF' 'XX is 'Dr FF, child psychologist'.

289. Whether or not that message was passed on to Mrs A and Patient A, both made it quite clear that they were not interested in any further counselling. Dr Webberley also stated:

'I also appreciate that the question will arise that should pubertal induction only be managed by a paediatric endocrinologist? In my practice if I had needed the assistance with the diagnosis or management of pubertal disorders, I would have referred to a paediatrician. In cisgender young patients who have not started puberty when expected, or who have abnormal physical appearance of the external genitalia, I would refer for any necessary investigations to establish a diagnosis. However, when the diagnosis for the absent male puberty is known, as was the case in Patient A and Patient B, the issue at hand is to manage the administration and monitoring of the sex hormone, in this case testosterone. This is something I feel competent to do.'

'I also reviewed advice on this matter and saw that in the NHS Interim NHS England Gender Dysphoria Protocol and Guideline 2013/14 … 'NHS England may commission a specialised Gender Identity Clinic (GIC) service from providers able to deliver the range of multi-disciplinary services described in this document, and offer effective and high-quality care for gender dysphoria. Historically, such services have been single-centre, consultant-led, multidisciplinary teams but other models, for example multi-centre, multi-disciplinary clinical networks involving General Practitioners with special interest in gender dysphoria, are not excluded. However, it is a requirement that both single-centre and multi-centre clinical network providers: ● Have an effective multi-disciplinary team (MDT) that meets regularly, either in person or through electronic communication ● Deliver patient care that is based upon individual care plans that are agreed and reviewed by the provider's multi-disciplinary team (MDT) ● Are able to offer the complete range of multi-disciplinary services described in this document ● Are able to meet team member training and quality standards that will be determined from time to time by NHS England.'

'I understood that if I needed help outside of my skills and knowledge then I would ask colleagues with other areas of expertise.'

290. The Tribunal understood her position to be that as she was competent to prescribe gender-affirming hormones, there was, in this instance, no need to consult a paediatric endocrinologist. In those circumstances, she contended that whilst she was willing to draw on the skills and input from members of a multidisciplinary team if it was necessary, as it was not, she did not.

291. Dr Q was the expert called by GMC who spoke to the MDT model. His view was that:

'there was a failure to provide the expected MDT approach and psychological assessment needed to confirm a diagnosis of gender dysphoria.'

292. However, the Tribunal took the view that his opinion was primarily based on the WPATHSOC7 and Endocrine Society Guidelines 2009 model of care, as practiced at GIDS. He acknowledged that he has never practised as a transgender specialist and that he had not considered alternative models of care. He also acknowledged that there was no evidence

that better outcomes could be achieved if a multidisciplinary team approach was followed. He said in evidence:

> *'A … There is a real question of what is the duty of care? I don't think that it's within my remit to determine what it is, but without that being changed, you would still have, as a clinician who is prescribing a medication that had long-term and far-reaching consequences for physiological and social functioning, you would want to make sure that there were the right set of professionals around that child to monitor that, track it and intervene when difficulties came up, because as a GP, you wouldn't be able to do all of that stuff, so that's where the duty of care would come in.*
> *That's where the necessity of having the availability of an MDT would be. That's not to say necessarily, from my reading of things, that Dr Webberley absolutely has to have a full MDT at her disposal, but I guess one of the things that I didn't see was use of extant services that had availability of an MDT. There didn't seem to be much backwards and forwards, much communication, sharing of information, proactive communication saying, "Look this thing has come up. How do we work together on that?" and I think there are probably a number of reasons for that that are not for me to say, but the MDT approach still needs to be there. It needs to be created in some way.*
> *…*
> *Q We will move on from that. A very broad question to you is is there any objective evidence that the management of gender dysphoria in terms of outcomes is better in an MDT than it is in a hub-and-spoke model.*
> *A I think that that would be where I don't have the background in being right at the edge of research in those things. In terms of citing the evidence base, that's probably where I would responsibly draw a line. I can comment on MDT provision and the pathways that we follow as standard within the NHS and then in the UK, but actually commenting on what outcomes would be probably wouldn't be for me to say, having not worked ---*
>
> *Q The one you refer to, 'the burden of rigour in benchmarking against other services'; surely what you're saying is it was incumbent on Dr Webberley to do that research. I accept that that's not your job, but Dr Webberley surely, to discharge that burden of rigour, would have looked at the spectrum of what was available. Is that not how she should have gone about things?*
> *A Yes, to figure out what it is that can be safely offered in the context of what else is on offer. I can see a scenario that I think may have existed for other patients. Again, I must remember this is a snapshot of three patients and Gender GP, for these three patients I didn't see much of – for example – sorry, I'm babbling now. Dr Webberley could have looked at other services and said, 'Right, they've got really, really long waiting lists. I can see people really quickly, but I can't provide the MDT provision. Can I do something for them or can I offer something that approximates what they've got and then set up really good lines of communication with them?' I think I've lost my grasp on the question, I'm so sorry.*

Q That's a helpful analysis of the situation, but my question isn't about waiting lists or anything like that. The start point is rigour of benchmarking, which is your point, and Dr Webberley's evidence is that she extolled a hub and spoke model, and in informing herself of what model to adopt, she looked to the University of California, San Francisco, which is a centre of excellence in transgender healthcare.
A Okay.

Q She felt that there were elements of that that were of assistance to her in setting up her own service. Is there anything wrong with that?
A No, and again I have seen the medical notes of three people who attended Gender GP. What I would want to see within that hub-and-spoke model, which may be completely appropriate, is that all of the risk factors were taken care of for the patients that I saw the medical notes for, and my concern then would be – I haven't been informed about there being a hub-and-spoke model in place. If that was in place, my worry then would be less about whether it was an MDT versus hub and spoke model and whether within the hub-and-spoke model there was sufficient iterative process to contain the risks that these children and adolescents presented, specifically around unresolved diagnoses and the management and identification of ongoing behavioural issues in response to having medications terminated by UCLH and because of histories of suicide, eating disorder and deliberate self-harm.'

Dr Q therefore countenanced a hub and spoke model provided it took care of the risks.

293. The issues for the Tribunal in respect of this allegation are therefore:

(i) Did Dr Webberley have the competence to prescribe testosterone to Patient A; and / or
(ii) Were there any reasons why she should have consulted elsewhere, with some form of multidisciplinary team.

294. The Tribunal accepts that prescribing testosterone to a 12 year old adolescent was unusual, and that it might have been advisable for Dr Webberley to have spoken to someone in the field such as Dr GG, who mentored Dr U, or perhaps Dr X, but it did not consider that there was a duty in this regard if she was competent to assess Patient A herself and to prescribe him with testosterone. The Tribunal relies on its analysis of Dr Webberley's competencies as set out in the relevant preceding paragraphs of this determination. The Tribunal relies on its analysis of Dr Webberley's competencies as set out in the relevant preceding paragraphs of this determination. It finds that Dr Webberley was competent to prescribe testosterone to Patient A.

295. The Tribunal accepted Dr Webberley's evidence that, in the case of Patient A, there were no reasons for her to have consulted elsewhere. The diagnosis of gender dysphoria was known, so the issue at hand was to manage the administration and monitoring of the sex hormone, which she felt competent to do without the input of other specialists or a

multidisciplinary team. There were no reasons for her to access other specialists. Had she needed that input, she would have accessed it.

296. In the circumstances, the Tribunal finds paragraph 1(c)(ii) not proved.

Paragraph 1

1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

d. ensure it was feasible for Patient A to receive the correct dosage of testosterone as prescribed by prescribing a metered dispenser rather than in sachet form;

297. In his report dated 19 March 2021, Dr P stated:

'To ensure that (Patient A) would receive the right dosage of testosterone, it would have been more appropriate to prescribe a metered dispenser of testosterone or a sachet that contains a lesser amount of testosterone. Not ensuring the feasibility for the patient to receive the right dosage is not at the level of adequate care.'

298. In her witness statement dated 9 August 2021, Dr Webberley observed that the use of Testogel sachets was recommended by the UCSF:

'Testosterone topical gel 1% 12.5-25 mg [...] may come in pump or packet form.'

She also noted that the Endocrine Society Guidelines 2009 advised that

'For the induction of puberty, we use a similar dose scheme of induction of puberty in these hypogonadal transsexual adolescents as in other hypogonadal individuals'.

299. Dr Webberley said that she examined the difference between giving injections and using gels or tablets. She made the point that injections present challenges for the patient: patients needed to make frequent trips to the GP or to self-administer. She added that the injection interval also causes marked peaks and troughs in patient's hormone levels with high levels just after taking the injection, and low levels by the time the next injection is due.

300. Dr Webberley said that she complied with GMC transgender guidance at the time. This was endorsed by the 'UK Good Practice Guidelines For The Assessment And Treatment Of Adults With Gender Dysphoria (RCPsych Report CR181, October 2013)'. She adopted a harm reduction approach, choosing the use of Testogel as the testosterone medication. Dr Webberley added that Testogel was, at the time,

'available affordably in sachet form, but more recently it has been made available in a metered dose dispenser.' She concluded by stating *'I looked at dosing schedules for*

patients, and took my main advice from the UCSF Guidelines for Primary Care and BSPED dosing schedules for the induction of puberty.'

She prescribed 12.5mg of Testogel to be used once daily from a sachet which contained 50mg of Testogel.

301. Dr P's evidence to the Tribunal was *'The amount of intended start dosage as prescribed by HW 12.5 mg testosterone was in my opinion appropriate.'* Dr P went on to state, however, that *'…the formulation prescribed, 50 mg in a sachet and then dispensed in 4 equal parts to be administered over 4 consecutive days raises some concerns. Firstly, it does not seem feasible to titrate the required dosage accurately. Secondly, the formulation may not remain stable for 3 days in the fridge once the sachet is opened. The concentration of testosterone may not continue to be evenly distributed within the gel.'*

302. Dr P was questioned about this by the Tribunal. When asked why he speculated that the testosterone might not be evenly distributed in the gel, he replied that this was a question for a pharmacist. With respect to the precision required in dosing, Dr P was asked which was better, a monthly injection resulting in a very high dose initially but decaying to a very low dose by day 28, or a topical gel that delivers 50 mg over four days at approximately 12.5 mg per day, Dr P agreed that the gels offer an 'elegant' alternative to injections.

303. Patient A's mother was questioned by the Tribunal about the practicalities of using the 50 mg gel pack. She stated that Patient A quickly became adept at dividing the gel into four equal portions and that once opened, they stored the sachet in an airtight box in the fridge to keep the contents fresh.

304. The Tribunal finds that whilst prescribing Testogel in 50 mg packs may not have been the ideal way to deliver 12.5 mg daily doses, it received no evidence that was an unsafe or ineffective way to accomplish this.

305. The Tribunal therefore finds Paragraph 1d of the Allegation not proved.

Paragraph 1

1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

e. assess Patient A's capacity to consent to treatment;

306. In her witness statement dated 9 August 2021, Dr Webberley stated:

'It was clear to me from the GIDS assessment report and by my own assessments of Patient A's written and verbal communication that he had the capacity to consent to this treatment. His Mother had no concerns in this regard and no concerns were raised at his GIDS and UCLH assessments. My assessments involved the gathering of

> *information by email, written messages, in-person meetings, and from external reports. All of these informed my assessment of this patient to consent to treatment, and to also consider the potential effects of delaying medical intervention.'*

307. In their oral evidence, both Patient A and his mother told the Tribunal that they considered they had sufficient information and knowledge about hormone treatment, having undertaken much research online via 'Google'.

308. The Tribunal has already concluded that Dr Webberley was competent to provide treatment to transgender people and people with gender dysphoria. Dr Webberley had the benefit of information provided to her by Patient A's mother, including a report prepared by Professor F, dated 16 September 2015, in which he states:

> *'He would like at this point to begin blocking puberty with the GnRH analogue Gonapetyl and has been declared Gillick competent to sign the consent form which he has done.'*
>
> and
>
> *'This includes being fully aware of the reversible loss of fertility potential, and that continuation of the gender transition pathway with testosterone treatment and sex reassignment surgery would cause the loss of her fertility permanently. After several discussions with ourselves and her clinicians at the Tavistock centre, [Patient A] has been declared competent ….'*

309. While the Tribunal noted that the treatment referred to in Professor F's report related to puberty suppression, the future prospect of stage two of the gender transition pathway, namely gender affirming hormones, was also broached with Patient A and his mother. That Patient A was deemed by GIDS to have the capacity to consent to puberty suppression, which might be followed by gender-affirming hormone therapy, is indicative of his capacity to make important decisions generally. The Tribunal finds that Dr Webberley was entitled to incorporate into her own assessment that Patient A had already been asked to contemplate gender-affirming therapy when consenting to puberty suppression therapy at GIDS.

310. The Tribunal therefore finds paragraph 1(e) of the Allegation not proved.

Paragraph 1

> 1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:
>
>> f. in the alternative to paragraph 1e, record any assessment of Patient A's capacity to consent;

311. Dr Webberley in her oral evidence accepted that she did not record an assessment of Patient A's capacity to consent. In her witness statement, Dr Webberley stated:

> *'It is my usual practice to only record negative findings in relation to capacity.'*

312. The Tribunal noted that clinicians assess capacity on a daily basis and it is not always deemed necessary to record every assessment, particularly when the decision in hand is prosaic. The Tribunal therefore asked Dr S to clarify whether it was necessary to record the assessment of Patient A's capacity to the proposed testosterone treatment. Dr S stated:

> *'Unfortunately, sir, there are examples of patients who sign consent forms when afterwards, when the process has been examined, that it's clear that the patient has not the capacity to give consent because of the information they've received is inadequate and doesn't cover all the issues involved. I'm not, for a moment, suggesting that that is the case with this patient, but what I must say is yes, I think in general practice, in sexual health, sexual and reproductive medicine, certainly in adult practice clinicians, including myself, have not written, 'Patient has capacity to give consent'. It's not routinely documented. I think in this circumstance though, where one is working in an area with limited evidence base, where there are well-known questions posed by professionals and by society about capacity of young people to make decisions, that it would be good practice, prudent, to document capacity.'*

313. The Tribunal accepted Dr S's evidence. Dr Webberley was seeking the consent of a young adolescent to undergo potentially irreversible and life-changing treatment. This was no prosaic matter: it was a decision of the utmost importance and in those circumstances the Tribunal finds that Dr Webberley had a duty to record her assessment of Patient A's capacity to give consent.

314. The Tribunal therefore finds paragraph 1(f) of the Allegation proved.

Paragraph 1

> 1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:
>
> > g. provide adequate follow-up care to Patient A after initiating testosterone treatment in that you failed to:
> >
> > > i. arrange assessments to evaluate Patient A's response to testosterone treatment, including:

315. Paragraph 1(g) is expressed in the plural. It does not simply refer to a first review consultation. It appears to stem from Dr S's report. He stated:

> *'Dr Webberley did not arrange adequate and appropriate follow up care for Patient (B). A reasonably competent General Practitioner with a special interest in gender care and sexual health at that time would have provided a review consultation a few weeks after initiation of testosterone therapy, in order to assess its bio-psycho-social impact and any adverse effects. A reasonably competent General Practitioner with a special interest in gender care and sexual health at that date would have arranged subsequent review consultations.'*

316. Dr S was not precisely supported in this regard by Dr P who was concerned that there should be regular (3 – 6 monthly) biological checks principally blood tests. In his report Dr W observed:

> *'Dr Webberley organised blood investigations to be carried out in January 2017 after Patient B started on testosterone at the end of October 2016. At the Nottingham Centre for Transgender Health we do exactly the same: we organise blood investigations and a follow up after approximately 3 months that the patient commenced cross-sex hormone treatment.'*

317. The Tribunal preferred and accepted Dr S's approach to follow up care. It found that Dr Webberley did have an obligation to provide adequate follow-up care to Patient A including arranging review consultations.

Paragraph 1

1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

g. provide adequate follow-up care to Patient A after initiating testosterone treatment in that you failed to:

i. arrange assessments to evaluate Patient A's response to testosterone treatment, including:

1. psychosocial development monitoring;

The Tribunal has noted the following from Dr Webberley's clinical notes in respect of Patient A:

15 April 2016	Dr Webberley wrote to her staff:	Advise Testogel …. Refer to Dr FF for counselling and support I will see him in 3 / 4 months in clinic with a T blood test
16 April 2016	Ms II wrote an email to Mrs A which included the following:	Dr Webberley would like to see Patient A 12 weeks after starting testosterone at the clinic in order to assess the dosage and check progress.

4 July 2016	Mrs A to Gender GP	I think I read somewhere that Patient A needs a 12 week follow up appointment after starting t. The 12 weeks will be on 14 July. Please advise.
5 July 2016	Ms JJ	Is this just blood tests for under 16
5 July 2016	Ms II	Yes T&E check
5 July 2016	Ms JJ	The tests that Patient A will need are two blood tests for testosterone and estrogen levels. If you need any further information please do not hesitate to contact us.
5 July 2016	Mrs A to Gender GP	So we do not need to come to Wales? Do we get blood tests at out doctors? Also I have not told the doctor Patient A is on Testosterone as he seemed quiet against the idea due to the fact that Tavistock has not approved. We missed our Tavistock appointment and they made another one for August I'm thinking of ringing and stating we do not need to attend anymore due to Patient A being on Blockers and coping fine. Please advise. Many thanks!
7 July 2016	Dr Webberley	Nice to hear from you! How are things going with Patient A – tell me about it. I have been looking forward to hearing from you.
7 July	Mrs A to Dr Webberley	Stating that she was confused as to whether she could get the blood tests done locally at her GP surgery or whether Patient A needed to come to Wales; Explaining that Dr H did not know that Patient A was on testosterone and saying that it he needs to go to their doctor for blood tests then they will; Giving an account of Patient A's physical, social and emotional progress including: Patient A has become a normal teenage boy, happy, loads to look forward to, smiling frequently and laughing more than I can remember him ever laughing. ……. He is like a different person … He truly is a remarkable, intelligent, maturing boy, who has growing in confidence and no longer the shell of his former self. ….
8 July 2016	Dr Webberley	WOW – what lovely story (tears in my eyes). Will think about the next steps and email you soon. X

10 July 2016	Dr Webberley	OK so we could do with a blood test to check his T and E levels. We can do this with a home finger prick kit if we need to. There is no urgency, just soonish. I have no doubt that this was right for Patient A, and I don't think you do. Would he be able to email me himself with his thoughts?
12 July 2016	Mrs A	Further email including a piece from Patient A in which he explains how he was (prior to testosterone) and then adds: Now I'm so much happier because my voice is breaking, which is proof to them that I am a boy, and they have stopped making awful comments and have even started saying things like: "Patient A, your balls have dropped!" That made me feel awesome. I find going to the Tavistock pointless, because XX askes non related and personal questions for an hour, and not only is it boring, it doesn't help me at all. I know we had to do it to get blockers, because we didn't know about you at the time but I don't want to go back as it is a waste of time. I really appreciate your help and how you have changed my life and made it better. You are mint Dr Webberley!
12 July 2016	Dr Webberley	Aw shucks! I have never been called mint before! I am honestly so pleased to have had the privilege to help. I shall create a shared care agreement and get back to you.

318. It is apparent from the passages extracted from Dr Webberley's clinical record that she was anticipating that she would review Patient A in person some 3 to 4 months after prescribing testosterone, at which time blood tests for testosterone and oestrogen would be taken. Although that review did not take place in person, the Tribunal was satisfied that the emails which Dr Webberley received from Mrs A on 7 July and 12 July 2016, the latter including a piece from Patient A, enabled Dr Webberley to monitor Patient A's psychosocial development and thereby enable her to assess his response to testosterone treatment. Although she did not see him in person as originally planned, there were reasons for this including his reluctance to undergo (yet another) assessment in person.

319. Dr S was concerned that Dr Webberley was not trained in childhood and adolescent developmental psychopathology, and observed that

'.. unless she had completed additional training in this field, she was not appropriately qualified to manage any aspect of [Patient A's] care for gender dysphoria but only diagnose the ordinary problems of childhood.'

320. However, the Tribunal considered that Dr Webberley did have sufficient expertise to determine whether Patient A's mental wellbeing was adversely affected by his social experience and therefore that she was able to assess the efficacy of the treatment he was receiving.

321. The information which Dr Webberley received in July 2016 from Mrs A and Patient A confirmed Dr Webberley's view that she had prescribed appropriately. The Tribunal was therefore not satisfied that Dr Webberley was under any obligation to arrange follow up care for Patient A in July 2016 by arranging an assessment to evaluate his response to testosterone treatment including psychosocial development monitoring.

322. However, after 14 July 2016, Dr Webberely did not regularly communicate with Mrs A and / or Patient A. Mrs A wrote an email to Dr Webberley on 9 August 2016 as follows:

'I have messaged a few times, yet have not received a reply. I am a little concerned! [Patient A] is due a blood test (actually it was four weeks ago). I have not received an update with what has happened with the shared care plan, so I am going to the doctors tomorrow and pray for a miracle, that they will help, regarding tests. I am not optimistic. [Patient A] is also due another prescription as his will run out next week! Please advise how we go about this and what to do with the online chemist as I cannot remember and cannot find the original email with instructions.

I received a letter with appointments for the Tavistock and UCL with the specialist – even though I didn't attend the last appointments. I have had to ring the Tavistock and explain that I am paying private for testosterone, explaining that I would rather have a happy son than no son at all. XX the family therapist has said that he wants to seem me and [Patient A] at an appointment August 26th. He also asked what dosage of testosterone [Patient A] was on, to which I replied I am not sure off the top of my head and he then asked who the doctor was. I said that I was not prepared to mention your name without your consent, even though it is completely legal.

I have no intention of keeping the appointment with XX or disclosing your name or any other information. He also said that the appointment he would like to find out who this doctor actually is. I was at a loss as to what to do and I still am as to what to do about tests, prescriptions due, care plan etc. As I currently feel out of the loop.'

Dr Webberley replied on 2 October 2016:

'Hi [Mrs A] I was wondering why I hadn't heard from you and now I see that your message didn't get through to my system. I am so sorry! How are things and what is

happening? Has your GP been helping out? My personal email is ………………. - do email me on there if this fails again.'

To which Mrs A responded on 16 October 2016

'How do. I have emailed numerous times to both email addresses to you secretary Ms II and also to your personal email address. We received no response even though you were aware that [Patient A] needed tests and his prescription had ran out. After 3 months of no response from you, no medication and four plus months from the time you advised us that [Patient A] would need tests, we had to seek advice from elsewhere! We have felt incredibly let down! I could perhaps understand one email slipping through the net, but not several to two different email addresses is a little difficult to believe.'

Best wishes

Ms II, the Clinic Manager, responded on 17 October 2016 as follows:

'I have emailed you directly from my email address in the hope that it is received. Please feel free to call me on …….'

The next two emails were from Ms II as follows:

2/1/17: *'Hi; Happy New Year* 😊 *let me know if you need anything. Best wishes Ms II'*

29/1/17: *'Hi, How is everything going? Can we help with anything at the moment? Best wishes Ms II'*

And the next from Dr Webberley as follows:

24/2/17: *'Hi [Mrs A] how are things with [Patient A]? I would really love to hear from you. Dr Webberley'*

323. The correspondence between Dr Webberley and Mrs A continued in the following days as set out below:

MON 07:11

'[redacted] accepted your request.'

From Mrs A:

'Hi,

I attempted to contact you and Ms II numerous times regarding the next prescription of testosterone, the blood tests that you stated were a necessity, and to let you know that without the authorisation of NHS professionals, my GP would not assist with this. However, I received no response for two whole months. You claimed that they had not been received, and that I should instead send messages to your personal email address, but I had already done this, in addition to sending messages to the email address of the secretary. While one or two could perhaps have slipped through the net, it didn't seem feasible that they all had gone wayward.
It was obviously hugely concerning that we had apparently been left devoid of guidance, advice, support, prescriptions or ability to get any tests performed, or even any correspondence. So, after the Tavistock had phoned me a few times, I had to admit that we had already been receiving treatment from elsewhere, though the details were not discussed. Dr G, [Patient A's] endocrinologist, personally rang me to ask what dosage of testosterone [Patient A] was receiving, and when I divulged the figure, he was exceptionally concerned, and dedared it was the dosage only an adult should take. He elucidated that a child of [Patient A's} age should only be taking a small fraction of the dosage, which would allow him to progress through puberty at the same rate as his peers, and mentioned that the breaking of the voice should take a few years -which I recognised to be true from when my older son's voice broke. The fact that [Patient A's] broke within two weeks, including other developments, was alarming to say the least. This new information, coupled with the fact that we felt so abandoned, assisted with the decision to continue seeking assistance from the NHS, as at that particular juncture we felt we had no other option! It wasn't until quite some time later that I received an email from you asking for an update, to which t responded, and then you replied that you hadn't received any of my messages. So, basically we are now back in the hands of the NHS, and left to wait the painful three years until [Patient A] is 16! However, travelling abroad for treatment is still an option being considered, as [Patient A] doesn't want to wait until then.
I wish you all the best, but do think that procedures should be thorough, and from what I have been told, you are not an endocrinologist, nor an expert with hormones, and that treating adults in this field Is fine, but treating children is a different kettle of fish entirely. This is obviously not from me - I just want what is best for my son, and feel like I'm in a horrendously tricky situation, and am rather depressed knowing that following the NHS guidelines will mean my son has to wait until he is 16, whereas other countries can prescribe from 14, and have prescribed, cross-sex hormones to children of 12 with great success!'

TUES 19:25

From Dr Webberley:

'Hi [redacted] firstly I am so sorry that my communications let you down. As you know, I feel so passionate about helping children like [Patient A] and I am gutted that this error on my system's part led to a break down in our communication. Secondly, I really hope [Patient A] is bearing up and if there is anything I can do to help then please do

let me know. I am aware of what has been happening with [Patient A's] care as Professor I from the UCL has made an official complaint about me to the GMC. His complaint, and Dr G 's letter, contain (In my opinion) a huge number of mistruths and misrepresentations. However, l actually welcome this investigation because if the investigation is fair and the outcome is in my favour, then it will allow care for children to change. As for the dosage, I prescribed [Patient A] a quarter of the adult dose, which I felt was right for [Patient A's] size. Please do keep in touch, please let me know how [Patient A] is nd [sic] if there is anything I can do to help you. Best wishes, Dr Webberley'

FRI 07:14

From Mrs A:

'Hi Dr Webberley,
As you know, due to the conflicting nature of the information I've received, I have been in turmoil as to what to do for the best I In response to your previous message, I am in the midst of writing a long reply directed at the GMC, which I am happy to send directly to them, or for It to be read out to them. In fact, I would be more than happy to attend the meeting, if this was allowed, though I couldn't promise I wouldn't become an emotional wreck. I will send you a copy once I have completed it.

As previously mentioned, [Patient A's] current behaviour is horrendous, to the point that I have broken down in tears several times. This is not normal behaviour of a child of Patient A's age as I have not witnessed it in any of my other three children, and my eldest is now 20. He has episodes of violence and is suffering from chronic depression, not seeming to care about anything anymore. He is adamantly against the route of antidepressants as he knows he is this way because he is currently being prevented from being who he is and who he should be. His behaviour troubles me immensely and after an eruption tonight it is having the effect of tearing our family apart.

I was told by the Tavistock in Leeds that if we continued along the road of seeking help from you, we would be unable to receive any assistance from the Tavistock, Professor F *or our GP, or even for blood tests. This worried me greatly, and our GP confirmed that without the approval of Professor* F*, they would be unable to assist [Patient A] on his journey. How dare they? I mean, surely it is our prerogative to acquire aid from elsewhere if our own doctors refuse us the help that [Patient A] requires. How can they allow my sone to suffer so much? The fact that I was unable to get in touch with you during this period seemed to only give us one option – to stay under the guidance, which [Patient A] has come to detest. Twice yearly we have to go to Leeds, where [Patient A] has to sit in a room with a therapist asking him questions, which he doesn't find remotely useful. The expensive trips to London only involve blood tests and a bone scan, along with a 10 minutes chatting to a doctor or Professor* F.

I am sobbing as I write this, as I can't see any solution to this predicament, other than to put him back on testosterone, but then we are frowned upon and effectively ostracised from our GP. All I want is for [Patient A] to be happy, and to be allowed to live unimpeded as the person he is. I can understand the GMC's position (of delaying the prescription of T) in cases of gender dysphoria that are abrupt or ambiguous, but a child who has never wavered from displaying repulsion at anything conveying their biological gender, going back to when they were just 9 months old (which is as early as they were able to display it), is a different case entirely.

Although it was often claimed by family and friends that [Patient A] was just a tomboy, and that this was a passing phase, I knew in my heart he was born into the wrong body – just like a hermaphrodite is born with both, transgender people are born with the wrong genitalia and hormones, etc. The cause certainly wasn't environmental, as XXX. Also, Professor F *stated that [Patient A's] bone growth from taking testosterone was abnormally rapid (that of a 14-year-old), but [Patient A] is actually exactly the same height and build as XXX who is progressing through puberty naturally. This could be explained by XXX. XXX.*

I have been having visions of him harming himself, and I couldn't cope with losing a child. The main thing [Patient A] was proud of was the fact his voice deepened, and everyone believed finally he was a boy, stating things like 'Ah, your balls have dropped, [Patient A]'. he was the happiest I have ever seen him in his entire life, as even in pictures of family holidays and festive periods from the past, there was always sadness in his eyes. This melancholy has returned, as his deep voice has changed and is getting higher in pitch. With tears streaming down my face, I ask for your help once again as we have reached a juncture where the situation is no longer manageable.

I feel like everything now makes sense, and that we have been misled and guided down a route that has made our situation worse. We will do whatever we have to do in order to finance every bit of medical help, if that is what it is going to take.'

TUES 19:25

From Dr Webberley:

'[redacted] oh God. Please bring [Patient A] to come and see me. Today. this weekend, Monday? Don't even mention finance, tell [Patient A] we are going to restart his puberty and then fight so that no child has to ever go through this again. (I can't promise not to cry too) x'

From Mrs A:

'[redacted] Thank you so much Dr Webberley, again I am sobbing.
With all of this, I have felt unable to cope. Recently, I rang Professor F *and left a*

message whilst crying, as I was in quite a state. He rang back the next day, asking what had happened. When I explained, he said that the hormones may not be being 100% blocked, and that he will prescribe the monthly blocker in addition to the puberty blocker of which [Patient A] is currently in receipt, which is meant to be given every 10 weeks, though [Patient A] now receives it every 8 weeks due to hormones "slipping through", as evidenced by his behaviour previously deteriorating vastly for the final couple of weeks of the 10-week course. However, he has been the recipient of the 8 weekly blocker for around a year, so why would estrogen start slipping through, after all of this time has elapsed? He mentioned that this could be a possibility, though seemed unsure, then after asking if the higher dosage of puberty blocker was safe, he stated it was and that this wasn't uncommon in these cases. Now I look back, I am piecing things together and many things do not add up 11 don't know how soon we can get to you as XXX. XXX and I will try to arrange getting to you for Monday, If I can, as I need to be back for Wednesday for work. I can't stop crying, you are the only person that has helped us and I can't believe it has taken me so long to see the light! I am happy to fight alongside you and do whatever it takes. Thanks again, I am extremely grateful! X'

From Dr Webberley:

'[Patient A's mother]
Just let me know when you can make it and we will sort it out. XXX. Really looking forward to seeing [Patient A] and getting him back on track x'

324. The correspondence cited above between August 2016 and February 2017 demonstrates that, notwithstanding the anguish which Mrs A and Patient A were experiencing, Dr Webberley did not deliver follow up care to Patient A in respect of psychosocial monitoring, or in fact physical monitoring and laboratory testing. Had she instituted a review system at the outset, she would not have been dependent upon Patient A or his mother requesting a review. If she was not going to arrange it herself, it was incumbent upon her to arrange for it to be provided by another.

325. In the circumstances, the Tribunal found Paragraph 1(g)(i)1 proved.

Paragraph 1

1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

g. provide adequate follow-up care to Patient A after initiating testosterone treatment in that you failed to:

i. arrange assessments to evaluate Patient A's response to testosterone treatment, including:

2. physical development monitoring;

3. laboratory testing;

326. The Tribunal has considered these 2 paragraphs together.

327. In his expert report Dr P, referring to the Endocrine Society Guidelines 2009, stated:

'The follow-up protocol of pubertal induction as published in 2009 states that every 3 months, anthropometry: height, weight, sitting height, Tanner stages and laboratory: LH, FSH, estradiol/testosterone must take place. In addition, every year laboratory: renal and liver function, lipids, glucose, insulin, glycosylated hemoglobin. Bone density using dual-energy x-ray absorptiometry must be determined to evaluate the strength of the bones. Bone age on x-ray of the left hand. In addition, in the section of the 2009 protocol on adults, the need for follow-up of blood pressure and laboratory: hemaglobuline/hematocrite (level of red blood cells in the blood), and lipids is emphasized in transgender males. It is important to follow-up on these parameters because adverse events such as hypertension and erythrocytosis (too many red bloodcells in the blood) can have serious clinical implications.'

328. He added that following the 2017 reiteration of the Endocrine Society Guidelines 2009:

'The follow-up frequency has changed to every 3-6 months for a consultation including physical examination as described above. Blood work is typically more frequent in the start phase and is less after stable maintenance dosage of the hormones is reached (as described in detail in the adult section of the 2009 guideline. During follow-up, bone density using DXA should be determined to evaluate the strength of the bones every 2-3 years to monitor bone mass accrual. A bone age determination is typically done yearly to follow-up on the growth potential until final height is reached.'

329. This is echoed by Dr Y of the Division of Endocrinology, Department of Pediatrics, University of California San Francisco, California in his paper Approach to the Patient: Transgender Youth: Endocrine Considerations as follows:

'Cross-sex hormone treatment in previously suppressed patients or in late pubertal patients not previously suppressed

1. Physical exam: height, weight, Tanner staging, blood pressure (for FTM, in particular); monitor for adverse reactions T 0 and q 3 mo

2. Hormonal studies: ultrasensitive LH, FSH, estradiol/T T 0 and q 3 mo'

330. Dr Webberley did not physically examine Patient A, nor did she arrange an assessment of his physical development. She arranged for blood tests to be carried out in

respect of testosterone and oestrogen, but there is no evidence that they were in fact carried out. On 9 August 2016 Mrs A informed GIDS that Patient A was receiving testosterone. Towards the end of August 2016, she confirmed that he was not taking testosterone any more. Patient A did not receive a repeat prescription of testosterone from Dr Webberley in the summer of 2016. The blood tests which Dr Webberley sought to arrange would not have reflected the guidance on laboratory testing above cited, nor in fact her own proposed shared care agreement with Patient A's GP. Further the Tribunal relies upon its reasoning in relation to paragraph 1(g)(i)(1) insofar as it refers to physical development monitoring an laboratory testing. In the circumstances, the Tribunal finds paragraphs 1(g)(i) 2 and 3 of the Allegation proved.

Paragraph 1

1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

h. inform Patient A's GP of the medication you were prescribing to A;

331. The Tribunal noted that, when Dr Webberley wrote to Patient A's GP on 23 March 2016, she stated:

'[Patient A] is desperate to start testosterone therapy to allow him to have a male puberty at the same time as his peers. He and his mother have no concerns at all that this is the right thing to do'

'The only way for [Patient A] to start testosterone is for him to seek private care, and …… to back up my feelings that it would be right for him to start treatment earlier than 16 / 18.'

'If you are in agreement, and have no concerns, would you be able to continue his blockers and testosterone prescriptions on the NHS, if I fully advise on his doses and blood monitoring and results?'

332. However, Dr Webberley did not later inform Patient A's GP that she had prescribed testosterone for Patient A on 19 April 2016. The Tribunal considered whether she was under a duty to do so. It recognised that this was a difficult decision for her as Dr H was not prepared to engage in a shared care agreement with her unless GIDS endorsed her decision to prescribe. She knew GIDS would not, but she had also reached the conclusion that prescribing testosterone for Patient A was the right decision. She also knew that Patient A's mother did not wish to disclose that Patient A was being prescribed testosterone.

333. The Tribunal had regard to the document entitled WPATHSOC7. In this it is stated:

'5. Communicate as needed with a patient's primary care provider, mental health professional, and surgeon.'

334. On balance, the Tribunal determined that Dr Webberley did have a duty to disclose to Patient A's GP that she was prescribing testosterone to him. It was the evidence of Dr S that if a patient prohibits the treating clinician from sharing of medical information with other clinicians when it is necessary to do so, the treating clinician may need to refuse to treat the patient.

335. In all the circumstances, the Tribunal found that Dr Webberley did have a duty to inform Patient A's GP of the medication she was prescribing to Patient A and she did not do so. The Tribunal therefore found paragraph 1(h) of the Allegation proved.

Paragraph 1

1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

i. seek a psychological assessment after Patient A's mental health deteriorated;

336. In his report dated 16 March 2021, Dr Q quoted a passage of a letter to Patient A's GP drafted by Dr Webberley on 8 March 2017 which stated:

'[Patient A's] behaviour and mental state have been in serious decline. [Patient A's mother] and the family have not known how to cope with it. [Patient A] and the family all feel that it is due to the withdrawal of testosterone and the puberty that it was allowing [Patient A] to have in line with his peers, and this has caused this massive deterioration in his mental health. [Patient A's mother] describes feeling that she feared for [Patient A's] life in terms of self-harm and suicide and that at that time she herself would not be able to cope with the thought of losing a child and it was almost worth pre-empting that horrific situation.'

337. Dr Q went on to opine:

'Whilst there was a medical understanding of the causes for this deterioration in mental health (due to testosterone withdrawal), there is no mention of referral to a psychological or mental health practitioner to fully assess and confirm this or the risk associated with the deterioration. It is conceivable that given the trigger for this episode was cessation of testosterone recommended by the Tavistock GIDS, that Dr Webberley reasonably assumed that they would be taking responsibility for the effect of their recommendation to cease the medication on [Patient A's] mental state as would be their (shared) duty of care. Were this the case it would have been proper to communicate with all concerned agencies and clinicians and develop a management plan. I cannot see evidence of any co-ordination over the management of this issue between the Tavistock clinic, UCLH GIDS and Gender GP.'

'There was a failure to include psychological input for this patient when their mental health deteriorated in response to a recommended medication change. This is of concern as testosterone medication did not appear to be being reinstated at any time in the near future and [Patient A's] psychological state remained unaddressed. There were concerns about safety mentioned by his mother.'

338. Dr Webberley first saw Patient A in February 2016. She prescribed testosterone to Patient A in April 2016. In consequence of a breakdown in communication between Dr Webberley and Patient A's mother, Dr Webberley did not correspond with Patient A or his mother between July 2016 and February 2017 when she saw him again. In the meantime, and in the context of that breakdown, Patient A's mother contacted GIDS again.

339. The Tribunal has had sight of an email, dated 28 September 2016, from Mr AA at GIDS to his colleagues. In the email, Mr AA sets out the background to Patient A's gender dysphoria, and that Patient A was prescribed testosterone by Dr Webberley. Mr AA goes on to say:

'The matter came to our attention about 2 months ago when [Patient A's] mother left a telephone message saying that [Patient A] had been on Testosterone for several weeks. His voice had broken and he was much happier. This triggered a joint GIDS/UCLH response. Professor F advised the family to stop taking the testosterone which they say they did from immediate effect.'

340. Dr Webberley contacted Patient A's mother on 24 February 2017. In an email to her, Dr Webberley wrote:

'Hi [Patient A's mother] how are things with [Patient A]? I would really love to hear from you. Dr Webberley'

341. On 27 February 2017, Patient A's mother responded advising Dr Webberley that Patient A was again in the care of GIDS and that Professor F had raised concerns about Patient A's physical development following the dose of testosterone prescribed to Patient A by Dr Webberley.

342. On 28 February 2017, Dr Webberley contacted Patient A's mother via email responding to the concerns raised.

343. In a detailed email, dated 3 March 2017, Patient A's mother set out the issues in respect of Patient A's mental health. This was the first time Dr Webberley became aware of Patient A's current or recent mental health problems and as a result, in an email response on the same date, Dr Webberley wrote:

'[Patient A's mother] oh God. Please bring [Patient A] to come and see me. Today, this weekend, Monday? Don't even mention finance, tell [Patient A] we are going to restart his puberty …'

344. The duty to undertake a psychological assessment of Patient A after his mental health deteriorated lay with GIDS, as suggested by Dr Q in his report, given that at the time Patient A's mental health deteriorated, he was under the care of GIDS and it was GIDS that advised the cessation of testosterone. The Tribunal therefore finds paragraph 1(i) of the Allegation not proved.

Paragraph 1

1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

j. adequately communicate with Patient A's other treating physicians at the Gender Identity Clinic at University College London Hospitals after you commenced testosterone treatment;

345. There is plenty of evidence that Dr Webberley sought to involve Patient A's GP in a shared care agreement before she prescribed testosterone to Patient A on 19 April 2016. However, she did not communicate with the physicians at GIDS either before or after prescribing testosterone.

346. From her own written and oral evidence, and from the evidence of Patient A's mother, and from Patient A's medical records, Dr Webberley was aware of the GIDS involvement in Patient A's case and the GIDS protocol –that should Patient A go elsewhere for treatment for his gender dysphoria, the treatment provided to him by Tavistock would be stopped. Dr Webberley stated in her witness statement and her oral evidence that Patient A and his mother had said they did not want her to inform GIDS that Patient A was being prescribed testosterone. Dr Webberley made no record of this in Patient A's medical records.

347. Dr Webberley was in a difficult position. As mentioned elsewhere, she prescribed testosterone for Patient A in April 2016 and March 2017 as she considered that this was in his best interests. But she was aware that disclosure of this to GIDS was most likely to have the consequence of GIDS ceasing to care for Patient A; and further that Patient A's mother did not wish the fact that Patient A was prescribed testosterone to be known to GIDS. Nevertheless, the Tribunal considered that there was a duty upon her to communicate with Patient A's other treating physicians. That duty is set out in paragraph 44a of Good Medical Practice.

348. The Tribunal therefore finds that Dr Webberley failed to communicate with Patient A's other treating physicians at the GIDS after she commenced testosterone treatment. It therefore found paragraph 1(j) of the Allegation proved.

Paragraph 1

1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

k. maintain an adequate record of Patient A's treatment in that entries in records were:

349. This paragraph of the Allegation stems from the report of Dr S in which he observed:

'Inadequate record-keeping:

The medical records kept by a reasonably competent GP are, in comparison with those kept by psychiatrists, usually in 'short note' or 'bullet point' form and omit most negative findings. However, allowing for this difference in record-keeping practice, Dr Webberley's patient records do not adequately describe Patient A's care. Entries by Dr Webberley are infrequent; some of her decisions are recorded by administrative staff, rather than personally, and it is not always evident as to who has made a record entry. The document appears to be a print-out of email correspondence and lacks important features of an Electronic Health Record.'

350. The Tribunal noted that this paragraph of the Allegation refers to Dr Webberley's record of Patient A's *treatment* as opposed to *care*, the latter being the subject of the corresponding paragraph in respect of Patient C.

i. infrequent;

351. In her witness statement dated 9 August 2021, and throughout her oral evidence, Dr Webberley maintained that she kept frequent records. Some of these were emails.

352. The Tribunal had before it Patient A's medical records as recorded on the Gender GP database system. These records include entries of communication between Dr Webberley and Patient A and his mother, as well as with Patient A's GP, and begin from the first contact Patient A's mother had with Dr Webberley prior to the first consultation. In the records, Dr Webberley provides details of the discussions had and the treatment.

353. The GMC did not expound on how the entries concerning Dr Webberley's treatment in the records may be regarded as infrequent. If the records reflected the treatment which Dr Webberley provided for Patient A, that would be acceptable. The GMC did not establish in evidence that this was not the case.

354. Dr Webberley's failure to provide adequate follow-up care to Patient A, as found by the Tribunal in respect of paragraph 1(g) of the Allegation would not be reflected in paragraph 1(k)(i) of the Allegation.

355. The Tribunal determined that the GMC has not discharged its burden of proof in respect of this allegation. It therefore finds paragraph 1(k)(i) of the Allegation not proved.

Paragraph 1

1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

k. maintain an adequate record of Patient A's treatment in that entries in records were:

ii. made by administrative staff;

356. The Tribunal noted entries had been made in Patient A's medical records by Dr Webberley's administrative staff.

357. The Tribunal received no evidence, expert or otherwise, from the GMC to indicate that the involvement of Dr Webberley's administrative staff in the maintenance of her patients' records was unacceptable in any way.

358. The Tribunal was not persuaded by the GMC's argument that Dr Webberley failed to provide good clinical care for Patient A by allowing administrative staff to maintain records of her treatment to Patient A.

359. In the circumstances, the Tribunal determined that the GMC has not discharged its burden of proof. It therefore finds paragraph 1(k)(ii) of the Allegation not proved.

Paragraph 1

1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

k. maintain an adequate record of Patient A's treatment in that entries in records were:

iii. unclear as to who had made them;

360. The Tribunal noted that whilst the entries in Patient A's records were attributed to individuals, the exact identity of those individuals was not always disclosed both in terms of the full name of the individual, and as to the position which he or she held at Gender GP. In particular it was not necessarily clear that the entries were made by a member of the administrative staff or by a healthcare professional. It might be that upon a thorough perusal of the electronic records as a whole, the identity and position of the person who made an entry could be ascertained. However, if a clinician were perusing the record at a later date, it should not be the case that he or she would have to conduct an investigatory exercise as to who completed the entries. That should be plain from the face of the record.

361. The Tribunal therefore found that Dr Webberley failed to maintain an adequate record of Patient A's care in that it was not clear who had made entries in the record. Accordingly, the Tribunal found paragraph 1(k)(iii) of the Allegation proved.

Paragraph 1

1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

k. maintain an adequate record of Patient A's treatment in that entries in records were:

iv. made using email print-offs rather than an electronic record system;

362. As mentioned, Dr S included the following in his observation about Dr Webberley's record:

'The document appears to be a print-out of email correspondence and lacks important features of an Electronic Health Record.'

363. Dr S was reflecting upon the record as provided to him. Paragraph 1(k)(iv) attempts to translate that reflection into an allegation. The Tribunal was concerned whether it should interpret the allegation as a criticism of Dr Webberley's practice of using email correspondence as a method of record keeping. Email correspondence is of course electronic, and does not depend on print-offs. In her witness statement, Dr Webberley stated that:

'The emails sent and received between myself and Patient A and his Mother form part of the record in the electronic medical health record system.

I apologise that the printing format of the records makes it difficult to read sometimes. However, the electronic health record system in real life is not a series of print-offs. I have included the screenshots as an example. This is exhibited as 'Exhibit 4'.'

364. The Tribunal has perused 'exhibit 4'. The screenshots did not give the Tribunal confidence that Dr Webberley was maintaining an electronic system which logged the care which she was providing for Patient A. It considered that a major component of her record was contained in the emails which she dictated, drafted and / or sent to her patients, their mothers and her staff. That reflected Dr Webberley's case.

365. However, the Tribunal determined that it should not interpret paragraph 1(k)(iv) of the Allegation as referring to entries made by Dr Webberley in the record by email, rather than through a conventional records database.

366. The Tribunal will say that it found Dr Webberley's system of recording care by email to be unsatisfactory. It did not produce a log or a narrative of the care which she was engaged to deliver to Patient A; it was therefore a 'lazy' system, one which depended on the time when Dr Webberley chose to draft or send an email. It was not direct, nor timely. It was passive in that it generated record keeping when there was a need to communicate with patient, parent, or staff. It meant for example that she did not record Patient A's capacity to consent.

367. The Tribunal concluded that Dr Webberley's system did not lend itself to proper record keeping.

368. Paragraph 1(k) of the Allegation refers to Dr Webberley's record of treatment. Whether or not the emails had to be printed off were in the view of the Tribunal not relevant to whether the record was adequate. In fact, notwithstanding the deficiencies of Dr Webberley's system, the Tribunal determined that the email entries do reflect consultations and discussions Dr Webberley had with Patient A and his mother, and they do set out details of agreed outcomes and proposed treatments. The Tribunal therefore determined that Dr Webberley did not fail to provide good clinical care for Patient A by making use of email print-offs. Therefore, the Tribunal finds paragraph 1(k)(iv) of the Allegation not proved.

Paragraph 1

1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

l. engage in and / or with an adequately trained and specialist multidisciplinary or interdisciplinary team, in that you did not seek input before and during treatment from:

i. a paediatric endocrinologist;

369. In respect of Paragraph 1(c)(ii) of the Allegation, the Tribunal found not proved that Dr Webberley failed to provide good clinical care for Patient A following the initial consultation with him dated 22 March 2016, by prescribing clinically-indicated treatment to Patient A in that testosterone was commenced without the input of a multi-disciplinary team beforehand. Paragraph 1(l)(i) of the Allegation makes a similar allegation in respect of the period before the inception of treatment by Dr Webberley, namely before she prescribed testosterone to Patient A. The allegation also embraces the period during treatment. The Tribunal relies upon its reasoning set out above in its determination in respect of paragraph 1(c)(ii) in considering paragraph 1(l)(i) of the Allegation both in respect of the period *before* treatment, and also *during* the period of treatment as the same considerations apply. In addition, the Tribunal relies upon the matters hereinafter set out.

370. Although, as mentioned, Dr Webberley had access to a multidisciplinary team, that team did not include a paediatric endocrinologist. Dr Webberley did not therefore seek input

before and during treatment of Patient A from a paediatric endocrinologist. The issue for the Tribunal to determine is, therefore, whether she had an obligation to do so.

371. The Endocrine Society Guidelines 2009 does not stipulate that hormones need to be given by a paediatric endocrinologist. The Endocrine Society Guidelines 2017 refer only to the 'clinician'. The WPATHSOC7 refers to the 'hormone prescriber'. In his publication Approach to the Patient: Transgender Youth: Endocrine Considerations dated December 2014, Dr Y did not stipulate that hormone treatment must be given by a paediatric endocrinologist. The Guidelines for Primary and Gender Affirming Care of Transgender and Nonbinary People issued by the University of California in 2017, upon which Dr Webberley relies, states:

> *'Providers of transgender youth care should be skilled at meeting the needs of young people presenting for care at any stage in their process. The care of transgender youth does not need to be limited to pediatric endocrinologists. General pediatricians, specialists in adolescent medicine, family medicine, medicine/pediatrics, as well as nurse practitioners, physician assistants and others are all potentially qualified to provide high quality care for transgender youth.'*

372. In his report Dr P observes:

> *'The experience and evidence of the use of testosterone gel for this indication and in this age group is still very limited, and should be used with caution and preferably by a paediatric endocrinologist in a (standardized) research setting.'*

373. Dr U stated in oral evidence:

> *'Q I know that you have dealt with the individual issues in relation to each patient and I am not going to go through all of those and I will ask you to adopt your report in due course. I would like you just to give some more assistance to the tribunal on these four areas, if possible. The first is at page 9. We can see that you deal with it at (II). It is in bold.*
>
> > *'In the United States, providers who provide hormone therapy for transgender youth come from a variety of specialties besides Pediatric Endocrinology.'*
>
> *Then you say that it certainly shouldn't be confined to endocrinologists. So can you just help us with some expanding views about that, if you would?*
> *A I would be glad to. I can certainly understand why paediatric endocrinologists were at the forefront of this field when it was developed, i.e. the Dutch model. When the Dutch doctors were, I think, thinking about this problem of young people who had a clear identity different from their sex assigned at birth, they were noting that going through that wrong puberty or dysphoria inducing puberty was problematic from a mental health perspective and also, hearing from adult patients, they were noting that the secondary sex characteristics that they developed made it harder for them or more*

difficult for them as adults to express themselves the way that they would to the world. As endocrinologists were thinking about this problem, they had had experience with use of, for example, GnRH analogue medications because those have been medications that had been used for precocious puberty for a long time and also the use of testosterone and oestrogen for pubertal induction as those medications are used for patients that are agonadal or have delayed puberty. So it makes sense to me that endocrinologists would be the people that came up with this, at the time, novel concept of using GnRH analogues in early puberty followed by testosterone or oestrogen again in later adolescents.

The use of these medications isn't particularly complicated. They are medications that can be prescribed by people other than paediatric endocrinologists. In fact, they are routinely prescribed by other providers for various reasons. GPs, for example, prescribe oestrogen as birth control, can prescribe testosterone for men with low testosterone levels, and adolescent providers or internal medicine doctors use these medications frequently. So learning how to prescribe them is not overall challenging if someone is motivated to do so.

I think that the most important thing for a provider to have when working with transgender children and adolescents and their families is a passion or knowledge and/or comfort with issues related to gender, gender identity, and gender dysphoria. So the champions of gender clinics in the United States come from various fields, paediatric endocrinologists, general paediatricians, adolescent medicine doctors, which I am not sure is an international field but is a specialty here, and then general practitioners, or family medicine doctors is the term we use here, are also working in this field and I think the thing that all of those doctors that work in this field have in common is an interest in working with transgender and gender diverse youth.

I think that this is a positive thing, number one, because a lot of paediatric endocrinologists, frankly, are not well suited for this work. I have colleagues in my department that are paediatric endocrinologists because they love the adrenal glands or they are thyroid experts and if you have them see a transgender patient and talk about their gender identity, they are going to feel very lost or uncomfortable. So the number of paediatric endocrinologists that also have expertise in working with gender identity is much, much less than the demand for services for trans youth and, frankly, I think many of the best providers in this field, and I say best because they think critically about gender and gender identity and are affirming, are not endocrinologists. So I can think of several providers across the US that I have a lot of respect for that come from various walks of life, so to speak, in the medical field, all tied together because of their passion for this particular patient population, this demographic, and then that passion influenced them to learn how to use these hormones effectively and safely and make them providers that, if a patient was moving to a different state, I would refer to them and know that my patient was in good hands, regardless of whether or not they were a paediatric endocrinologist.

Q As I said, the other side of that coin, you touched on the issue of family doctors, and I am going to call them GPs but, as you said, the terms are different but they cover the same ground. Do GPs prescribe for transgender youth and adolescents in the United States in the sorts of practices that we are familiar with here, in other words, not in a hospital setting?
A Yes, there are some GPs that provide that care in the United States. I think that many of the largest gender clinics in the United States are run by either adolescent medicine doctors, paediatric endocrinologists, but there are GPs even in the state that I work in that provide this care to children, adolescents, and do so effectively.

Q Is there any bar on them prescribing either blockers or testosterone to their patients?
A There is not.

Q Your experience of general practitioners in the way that you have described, do they have any qualities, and I am talking generally, in regard to this area of medicine?
A Could you repeat that?

Q Yes. I am sorry. I may have gone off. Do general practitioners certainly in the field that you have come across have certain qualities or abilities in dealing with transgender youth that you think are relevant to that area of medicine?
A I do. I think one of the qualities that GPs have that may make them very well suited for this field is their training in the care of the whole individual. So if an endocrinologist, a paediatric endocrinologist, is very well trained in how hormones work but less so in taking a psychiatric history or making an assessment on depression, a GP does that every day. I think another quality that a GP may have that might make them potentially a better suited candidate for providing this care is that they can maintain a relationship with the patient and take care of all of their health needs, instead of having to see multiple professionals, a GP and a specialist, that they can limit the number of providers they have to see and take care of the whole patient in addition to their gender needs.'

374. Dr Webberley stated in her witness statement at paragraphs:

'102. The medicines used in this field are ones that I was well used to prescribing in General Practice and in my Sexual Health Clinics. The puberty blockers, GnRH Agonists, are used to suppress hormone production in people with prostate cancer and people undergoing fertility treatment, or people with endometriosis and children with precocious (early) puberty. I am very used to prescribing testosterone to people who have low testosterone levels, and oestrogen to those with low oestrogen levels.

129. I acknowledge that, in the guidance, many references can be found to the involvement of a paediatric endocrinologist. However, my evaluation of the intention was that if a paediatric endocrinologist with the required skills and knowledge for this

care was available for consultation then that was of course of benefit, particularly in complex cases, but not mandatory.

130. When I reviewed the provision of care in the UK, I noted that Professor F was on the paediatric specialist register, although clearly a specialist in the area of paediatric endocrinology. I saw that there was a sub-specialty register for paediatric endocrinology, because Professor I was on that register, and yet he did not have any experience in the care of transgender patients.

131. I recognised that the lead clinicians from the adult UK services came from a wide variety of specialties, including General Practice and Sexual Health. Dr S, the Chair of the Clinical Reference Group, had the same qualifications and experience as myself. I also understood that the mainstay of prescribing for transgender patients was done by GPs, under a shared care agreement, but that GPs should still have the necessary understanding of such medicine to prescribe under a shared care agreement.

132. I also appreciate that the question will arise that should pubertal induction only be managed by a paediatric endocrinologist? In my practice if I had needed the assistance with the diagnosis or management of pubertal disorders, I would have referred to a paediatrician. In cisgender young patients who have not started puberty when expected, or who have abnormal physical appearance of the external genitalia, I would refer for any necessary investigations to establish a diagnosis. However, when the diagnosis for the absent male puberty is known, as was the case in Patient A and Patient B, the issue at hand is to manage the administration and monitoring of the sex hormone, in this case testosterone. This is something I feel competent to do.

133. If I needed the input of an endocrinologist, then I would seek advice according to options local to the patient. For example, if it was for a bone density entry or bone age scan, then I would refer to the local paediatric service at a local hospital. If it was for advice on the management of induction of puberty, then I would access local paediatrics. If it was for the care related directly to transgender patients, I would seek advice from my international colleagues. In February 2016, [Ms AB] *of Mermaids and I had confirmed connections with Dr GG to 'provide her with 'remote' assistance for anything endocrine which may fall outside of her current knowledge.'*

375. The Tribunal has looked at the contemporaneous documents which Dr Webberley issued to Patient A's GP relating to the transgender care of Patient A should he accede to a shared care agreement as follows:

(i) The information to assist GPs with Transgender issues.
(ii) Guidelines for use of Masculinising therapy in Gender Identity Disorder, Shared Care Protocol for GPS.

376. Dr P stated that Dr Webberley's Informed Consent Form to start testosterone provided well-written information towards the advantages and disadvantages of the use of

testosterone in transgender care. The Tribunal considered that this documentation was impressive and that it indicated that Dr Webberley had attained an impressive degree of competence in the treatment of transgender care. It recognised that she did not provide adequate care to Patient A after initiating testosterone treatment as found in respect of paragraph 1(g)(i)(2) and (3). However, the documentation which she produced suggests that this was a failure of performance rather than reflects her overall competence in this regard.

377. By reason of the foregoing, the Tribunal does not find that Dr Webberley had a duty to seek input before and during treatment from a paediatric endocrinologist, as it accepted that she had the competence to prescribe hormones.

378. It therefore found paragraph 1(l)(i) of the Allegation not proved.

Paragraph 1

1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

l. engage in and / or with an adequately trained and specialist multidisciplinary or interdisciplinary team, in that you did not seek input before and during treatment from:

ii. a mental health practitioner;

379. In respect of Paragraph 1(b)(ii) of the Allegation, the Tribunal found not proved that Dr Webberley failed to provide good clinical care for Patient A following the initial consultation with him dated 22 March 2016, by not arranging for Patient A to be adequately examined prior to prescribing testosterone treatment including a psychological assessment to confirm a diagnosis of gender dysphoria. Paragraph 1(l)(ii) of the Allegation makes a similar allegation in respect of the period before the inception of treatment by Dr Webberley, namely before she prescribed testosterone to Patient A. The Tribunal relies upon its reasoning set out above in its determination in respect of paragraph 1(b)(ii) in considering paragraph 1(l)(ii) of the allegation in respect of that period. In addition, the Tribunal relies upon the matters hereinafter set out.

380. Dr Webberley deals with this in her witness statement as follows:

'I had suggested a referral to Dr FF, child psychologist, for support should it be needed, but the records do not indicate whether that took place or not. 'Refer to Dr FF for counselling and support.' I also signposted the patient and Mother to my counselling team, and I understand from Ms DD that she supported the family. I was confident in the reports from GIDS and my own mental health assessments in order to confirm the diagnosis and management plan.'

381. It is clear that it was Dr Webberley who made the initial and subsequent assessments of Patient A, and that in his case, she did not seek input from a mental health practitioner. The Tribunal must therefore address the issue as to whether she had a duty to do so. Dr Webberley's case is essentially that she was following a different care pathway to that of GIDS. Instead of utilising the mental health professional in a gatekeeper role, Dr Webberley adopted the informed consent model. She had before her a patient who was gender dysphoric. He had been so diagnosed at GIDS in September 2015 and had been accepted into their early intervention protocol. Upon the basis of the information which she had before and on the occasion of her first meeting with Patient A, she was able to confirm that assessment. She prescribed testosterone. By reason of the information which she received in July 2016, she was able to assess that the testosterone treatment was addressing that dysphoria. Following the breakdown of communications with Mrs A from about July 2016, she heard again from Mrs A in February 2017. She heard that:

> *'As previously mentioned, [Patient A's] current behaviour is horrendous, to the point that I have broken down in tears several times. This is not normal behaviour of a child of [Patient A's] age as I have not witnessed it in any of my other three children, and my eldest is now 20. He has episodes of violence and is suffering from chronic depression, not seeming to care about anything anymore. He is adamantly against the route of antidepressants as he knows he is this way because he is currently being prevented from being who he is and who he should be. His behaviour troubles me immensely and after an eruption tonight it is having the effect of tearing our family apart.*
>
> *I was told by the Tavistock in Leeds that if we continued along the road of seeking help from you, we would be unable to receive any assistance from the Tavistock, Professor F or our GP, or even for blood tests. This worried me greatly, and our GP confirmed that without the approval of Professor F, they would be unable to assist [Patient A] on his journey. How dare they? I mean, surely it is our prerogative to acquire aid from elsewhere if our own doctors refuse us the help that [Patient A] requires. How can they allow my sone to suffer so much? The fact that I was unable to get in touch with you during this period seemed to only give us one option – to stay under the guidance, which [Patient A] has come to detest. Twice yearly we have to go to Leeds, where [Patient A] has to sit in a room with a therapist asking him questions, which he doesn't find remotely useful. The expensive trips to London only involve blood tests and a bone scan, along with a 10 minutes chatting to a doctor or Professor F.*
>
> *I am sobbing as I write this, as I can't see any solution to this predicament, other than to put him back on testosterone, but then we are frowned upon and effectively ostracised from our GP. All I want is for [Patient A] to be happy, and to be allowed to live unimpeded as the person he is. I can understand the GMC's position (of delaying the prescription of T) in cases of gender dysphoria that are abrupt or ambiguous, but a child who has never wavered from displaying repulsion at anything conveying their biological gender, going back to when they were just 9 months old (which is as early as they were able to display it), is a different case entirely.*

> *Although it was often claimed by family and friends that [Patient A] was just a tomboy, and that this was a passing phase, I knew in my heart he was born into the wrong body – just like a hermaphrodite is born with both, transgender people are born with the wrong genitalia and hormones, etc. The cause certainly wasn't environmental, as XXX. Also, Professor F stated that [Patient A's] bone growth from taking testosterone was abnormally rapid (that of a 14-year-old), but [Patient A] is actually exactly the same height and build XXX who is progressing through puberty naturally. XXX. Professor F initially requested that XXX attends future appointments for blood tests, and to compare and contrast their height and growth, XXX.*
>
> *I have been having visions of him harming himself, and I couldn't cope with losing a child. The main thing [Patient A] was proud of was the fact his voice deepened, and everyone believed finally he was a boy, stating things like 'Ah, your balls have dropped, [Patient A]'. he was the happiest I have ever seen him in his entire life, as even in pictures of family holidays and festive periods from the past, there was always sadness in his eyes. This melancholy has returned, as his deep voice has changed and is getting higher in pitch. With tears streaming down my face, I ask for your help once again as we have reached a juncture where the situation is no longer manageable.*
>
> *I feel like everything now makes sense, and that we have been misled and guided down a route that has made our situation worse. We will do whatever we have to do in order to finance every bit of medical help, if that is what it is going to take.'*

382. Following that email, Dr Webberley saw Patient A at her clinic on 8 March 2017. Following that meeting she once again prescribed testosterone. Dr Webberley's pathway was to identify Patient A's continuing need and to meet that need with the relevant treatment, in Patient A's case, testosterone. Dr Webberley rejected the GIDS approach of suspending puberty at an early stage and allowing Patient A to experience life without the encroachment of either feminising or masculinising body changes. Dr Webberley rejected the notion of allowing the young person to continue with his psychological exploration following the anticipated easing of his initial distress and so allowing his reflective capacity to increase. In Patient A's case that distress did not ease. He knew exactly what he wanted and he could not wait for it to be prescribed.

383. The Tribunal also noted the NHS document *'Operational Research Report following Visits and Analysis of GICs in England'* issued in 2014, albeit in relation to adult GICs. In this there is a passage which states:

> *'Gender specialists may be from many different clinical backgrounds, some specialising in mental health: psychologists, psychiatrists, counsellors or therapists, but they may also be GPs, endocrinologists, ….'*

384. In his report, Dr P refers to the WPATHSOC7 and other guidelines:

‘For minors aged under 16 a MDT approach is required as underlined by the professional organisations (WPATH, EPATH, Endocrine Society). There is debate whether – contrary to adult care – a psychiatrist should be part of the team. Since psychiatric problems, such as internalizing problems, i.e., anxiety and depression, increased incidence of suicidal behaviours, and autism spectrum disorders are more prevalent in children and adolescents with gender incongruence in many centers of expertise a child and adolescent psychiatrist participates in the MDT. In West-European countries, the psychiatrist does an overall mental health evaluation but the diagnostic sessions with the psychiatrist are also aimed to address these possible coexisting problems. Assessment of the gender diverse adolescent is done by MHP. The SOC 7th states the following recommended minimum credentials for mental health professionals who assess, refer, and offer therapy to children and adolescents presenting with gender dysphoria: Meet the competency requirements for mental health professionals working with adults, as outlined in section VII; Trained in childhood and adolescent developmental psychopathology; competent in diagnosing and treating the ordinary problems of children and adolescents.’

385. However, the Tribunal also noted a footnote in the WPATHSOC7 which states:

‘Note that WPATH7 is primarily written for an American audience; the term “mental health professional” does not refer exclusively to a psychiatrist or clinical psychologist. It is used to exclude graduates with a Bachelor’s degree in psychology and no clinical training. ‘

386. By contrast, the Tribunal noted Dr W’s view concerning the involvement of a multidisciplinary team to include a mental health practitioner. He accepted Dr V’s view that the transgender clinician need only seek input from specialist members of the multidisciplinary team if it was necessary. Neither Dr W, nor Dr V considered that it was necessary in Patient A’s case.

387. The Tribunal relies on its analysis of Dr Webberley’s competencies as set out in the relevant preceding paragraphs of this determination.

388. The Tribunal has reached the view that Dr Webberley was not under a duty to seek the views of a mental health practitioner before and during her treatment of Patient A with testosterone. She was capable of carrying out the necessary assessments herself. Patient A had reacted against what he considered to be the irrelevant, time consuming assessments that he had experienced at GIDS. Paragraph 1(l)(ii) is therefore found not proved.

Paragraph 1

1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

l. engage in and / or with an adequately trained and specialist multidisciplinary or interdisciplinary team, in that you did not seek input before and during treatment from:

iii. LGBT and trans organisations which Patient A was attending.

389. Dr P was the only expert who supported the proposition that Dr Webberley had a duty to seek input from LGBT and trans organisations which Patient A which was attending before and during treatment. Patient A had been directed towards Dr Webberley by Mermaids in the first place. Dr P stated in his report:

'There was also a failure to provide regular MDT review either through direct provision of additional disciplines via Gender GP or through liaison with involved services such as Mermaids or the LGBT group that HS was attending.'

390. The provenance of this observation by Dr P presumably came from the Endocrine Society Guideline 2009 which states as follows:

'Because early adolescents may not feel qualified to make decisions about fertility and may not fully understand the potential effects of hormones, consent and protocol education should include parents, the referring MHP(s), and other members of the adolescent's support group. To our knowledge, there are no formally evaluated decision aids available to assist in the discussion and decision regarding future fertility of adolescents or adults beginning sex reassignment treatment.'

and WPATHSOC7

'For some transsexual, transgender, and gender-nonconforming people, an experience in peer support groups may be more instructive regarding options for gender expression than anything individual psychotherapy could offer (Rachlin, 2002). Both experiences are potentially valuable, and all people exploring gender issues should be encouraged to participate in community activities, if possible. Resources for peer support and information should be made available.'

391. The Tribunal readily accepts that there will be an advantage in putting a transgender person in touch with support groups, but it does not consider that in the case of Patient A, Dr Webberley had an obligation to obtain any further input from Mermaids. In any event she would have required Patient A's consent for her to contact Mermaids. His main concern was to receive the testosterone which she could offer. He had no interest in discussing matters further. Moreover, the Tribunal reflected that a GP has some advantage over a specialist in this regard, since a GP will have a holistic approach. The Tribunal therefore found paragraph 1(l)(iii) not proved.

Paragraph 2

2. In treating Patient A as set out at paragraph 1 above, you:

a. failed to adhere to the following professional guidelines:

i. Endocrine Society Professional Guidelines (2009);

ii. World Professional Association for Transgender Health Standards of Care (7th Edition);

392. The Tribunal has set out in a preceding section of this determination a detailed exposition of the framework of transgender healthcare in the period 2016 to 2017. In particular this examined the role and relevance of the two professional guidelines to which paragraph 2(a) of the Allegation refers ('the Guidelines'). The Tribunal considered them against the evolution of transgender care in the international medical, academic, social and professional context.

393. The Tribunal finds that the Guidelines were precisely that: guidelines. Further, the Tribunal noted in paragraph 16 of its determination, the flexibility of the WPATHSOC7. In short, the Tribunal does not find that Dr Webberley was under an obligation to follow the Guidelines.

394. The Tribunal adds that the Guidelines were, at the material time, of enormous importance in the care of transgender health, and that any practitioner practising medicine in that field had an obligation to have regard to them, as opposed to having an obligation to adhere to them. The Tribunal finds that Dr Webberley did have regard to them. That is not to find that she never departed from them – she clearly did on occasion; nor that she did not follow them when she might have done. However, that is not a finding that Dr Webberley failed to adhere to the Guidelines. Accordingly, the Tribunal finds paragraph 2(a)(I – ii) of the Allegation not proved.

Paragraph 2

2. In treating Patient A as set out at paragraph 1 above, you:

b. knew or ought to have known you were acting outwith the limits of your competence as a General Practitioner with a special interest in gender dysphoria.

395. The Tribunal relies on its analysis of Dr Webberley's competencies as set out in the relevant preceding paragraphs of this determination.

396. Patient A was an adolescent transman who presented to Dr Webberley in 2016 with what was at that time referred to as gender dysphoria. He was aged 11 years and 10 months when his mother first contacted Dr Webberley for help.

397. The care in question involved the diagnosis and assessment of gender dysphoria and the prescription of testosterone to initiate a masculine puberty.

398. The GMC case in respect of paragraphs 2b of the allegation was summarised by Mr Jackson QC in his opening note. He stated: *'Dr Helen Webberley did not have the required 'competence' (referenced in GMP) to embark on the role of lead clinician in the provision of such care, in a primary care context, with all its associated complexities – rather, it was for her to restrict her role to prescribing such medication in the context of a multidisciplinary team ('MDT') approach, with its important and essential prior input from specialists, such as from a paediatric endocrinologist, and having obtained detailed psychological assessment, as outlined in the NHS Guidance.'*

399. The GMC case against Dr Webberley was therefore built on a view that the care of transgender adolescents is complex and that, in consequence, the care of Patient A could only be delivered within a multidisciplinary team with input from specialists, particularly those from the disciplines of psychology/psychiatry and paediatric endocrinology. The GMC alleged that Dr Webberley, a GP, was not competent to deliver the care in question and that it was not delivered within a multidisciplinary team setting.

400. Dr Webberley was reported to the GMC by fellow doctors. As mentioned, the GMC has received no complaints about Dr Webberley from any patients.

401. The Tribunal acknowledges that there is no evidence before it to suggest there have been any complaints made to the GMC about Dr Webberley from any patients. It finds, however, that whilst successful outcomes may evidence competence, it does not follow that an absence of complaints confirms competence. An incompetent doctor puts patients at risk of harm, even if that risk does not lead to actual harm. The Tribunal therefore makes clear its unequivocal endorsement of the tenet that doctors must practise within the limits of their competence.

402. The Tribunal relies on its analysis of Dr Webberley's competencies as set out in the relevant preceding paragraphs of this determination. It found that Dr Webberley was competent in the roles of mental health professional and hormone prescriber; and that she adopted a hub-and-spoke approach to her care for Patients A, B and C, referring them to specialists if and when required. She was competent to determine when such referrals were necessary. Dr Webberley was not bound to follow precisely the WPATHSOC7 or Endocrine Society Guidelines 2009 guidelines, although she did avail herself of the guidance therein. She was at liberty as an autonomous medical practitioner to look to alternative guidance and did so. Her reliance on the UCSF Guidelines was in accordance with a responsible body of expert medical opinion.

403. The Tribunal therefore finds paragraph 2(b) of the Allegation not proved.

<u>Patient B</u>

Paragraph 3

3. Following an initial consultation with Patient B on or about ~~11~~ 10 August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

a. obtain an adequate medical history for Patient B, in that you failed to elicit information about:

404. The Tribunal noted that this paragraph of the Allegation and the particulars thereof reflect a passage in Dr S's report as follows:

'Dr Webberley's records do not document a medical history for Patient [B] *adequate for diagnostic assessment and treatment planning. An 11th August 2016 entry in her records includes a description of Patient* [B]*'s gender identity development, adaptations Patient* [B] *made to improve gender congruence, some information about their mental health a* [sic] *self-harm, sources of support and a discussion of Patient [B]'s reproductive plans. Patient* [B] *was 16 at the time; there is no record of their general developmental history, record of age at onset of puberty and subsequent pubertal development, physical and mental health history, medication use, smoking, alcohol or substance use, or of any forensic history. If an adequate medical history had been taken but not documented, it would fall below the standard expected of a reasonably competent General Practitioner with a special interest in gender care and sexual health. If it had not been taken, this would fall seriously below the standard expected of a reasonably competent General Practitioner with a special interest in gender care and sexual health to a far greater extent than if it had not been documented.'*

405. The Tribunal noted that Dr S was never furnished with the medical questionnaire completed by Patient B and his mother on 12 July 2016.

Paragraph 3

3. Following an initial consultation with Patient B on or about ~~11~~ 10 August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

a. obtain an adequate medical history for Patient B, in that you failed to elicit information about:

i. general development history;

406. Dr S has not provided any information which might explain what he meant by developmental history. The Tribunal considered that developmental history would include developmental milestones in a person's life such as walking, speaking, face recognition, intellectual and age-related physical development, making friends and communication skills.

407. The Tribunal noted the email sent from Dr Webberley's clinic to Patient B on 12 July 2016 in which it states:

> *'I am going to speak to our Clinic Manager, Ms II and see when there are appointments available. In the meantime could you fill in the attached forms and return them to me? ….'*

408. The Tribunal was not able to ascertain whether the 'Child Psychological Questionnaire' which reads as though it was completed by Patient B, whether or not he received assistance from his mother. The form, which forms part of his patient records, was one of the forms attached to that email. The 'Child Psychological Questionnaire' is undated. The form contains questions relating to any childhood illnesses, any learning disorders, and significant life events. The responses provided in the questionnaire, which would have been completed by or on behalf of Patient B, include his family and social upbringing, his experiences at school, when he realised he was transgender and how that made him feel, etc.

409. The Tribunal understands that it may be good practice to establish this information as a baseline before prescribing any treatment, but it is difficult to see why Dr Webberley would need to elicit such information when Patient B was consulting her in relation to his transgender issues. The Tribunal considered that the sending of the form to be completed by Patient B went some way to eliciting information about his developmental history and other information. The Tribunal was of the view that, whilst it is not recorded in Dr Webberley's clinic notes, if there were any developmental issues, these would have been raised when Patient B completed the 'Child Psychological Questionnaire'. Whilst the Tribunal appreciates that as a baseline, this information may have been useful, it was not necessary or a pre-requisite. The Tribunal received no evidence as to how Patient B's development history related to or impacted on the treatment he sought.

410. In view of the evidence before it, the Tribunal was not satisfied that the GMC had discharged its burden of proof in relation to this allegation. It therefore found paragraph 3a(i) of the Allegation not proved.

Paragraph 3

3. Following an initial consultation with Patient B on or about ~~11~~ 10 August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

a. obtain an adequate medical history for Patient B, in that you failed to elicit information about:

ii. age of onset of puberty and subsequent pubertal development;

411. The Tribunal again had regard to paragraph 4 of Dr S's report of 18 December 2019, as set out above. The Tribunal noted that in her letter to Patient B's GP, dated 11 August 2016, Dr Webberley wrote:

> '*When puberty started* [Patient B] *wasn't really aware of what Transgender meant and went through a nasty time of anxiety and depression, becoming withdrawn and his school grades really suffered and there was an instance of self-harm, but no one really understood what was behind all of this. When* [Patient B] *was about 13 he understood what transgender was and as many of these young patients do, read extensively about it and understood exactly what this meant for him.*'

412. The Tribunal considered, from this, that a discussion had taken place between Dr Webberley and Patient B, during which Dr Webberley elicited this information.

413. The Tribunal therefore found paragraph 3a(ii) of the Allegation not proved.

Paragraph 3

3. Following an initial consultation with Patient B on <u>or about</u> ~~11~~ <u>10</u> August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

a. obtain an adequate medical history for Patient B, in that you failed to elicit information about:

iii. physical history;

414. Again, the Tribunal had regard to paragraph 4 of Dr S's report of 18 December 2019, as set out above. The Tribunal noted that Dr S did not go on to explain what he meant by 'physical history'.

415. The Tribunal had regard to the 'Family and Health' and 'Gender Identity' sections of the questionnaire, which aimed to elicit information such as:

> Patient B's medical history, whether anyone in the family were or had suffered from health or family mental health issues, whether Patient B ever wanted to harm himself, and whether Patient B had any other problems which should be known, how other people think about Patient B's gender? And did they think of him as Male or Female?, and whether Patient B had tried to alter his appearance at all to resemble his 'preferred' gender?

416. In relation to this last question, Patient B responded:

'I cut my hair short two years ago, and it's stayed at the same length. For a time I attempted to lose weight so as to lose female curves but then realised this wasn't possible to the extent I needed it so I stopped. I use binders to flatten my chest to give the impression of a flat male chest. I wear exclusively male clothes.'

417. The Tribunal considered that the questionnaire was designed to elicit Patient B's physical history and achieved that objective. If there was anything in relation to Patient B's physical history to mention, Patient B or his mother would have mentioned it in the form.

418. It therefore determined that Dr Webberley did not fail to elicit Patient B's physical history. It found paragraph 3a(iii) of the Allegation not proved.

Paragraph 3

3. Following an initial consultation with Patient B on **or about** ~~11~~ **10** August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

a. obtain an adequate medical history for Patient B, in that you failed to elicit information about:

iv. mental health history;

419. Again, the Tribunal had regard to paragraph 4 of Dr S's report of 18 December 2019, as set out above.

420. The Tribunal had further regard to the 'Family and Health' section of the questionnaire. In the questionnaire there is a question entitled *'Are any of you suffering from or have suffered from health or family mental health issues *'* Patient B responded by stating:

'Some members of my family suffer from an underactive thyroid which they take medication for.'

421. The Tribunal also had regard to Dr Webberley's letter to Patient B's GP, dated 11 August 2016. The Tribunal noted that by and large, the letter covered matters relating to Patient B's mental health. Dr Webberley wrote:

'When puberty started [Patient B] *wasn't really aware of what Transgender meant and went through a nasty time of anxiety and depression, becoming withdrawn and his school grades really suffered and there was an instance of self-harm, but no one really understood what was behind all of this. When* [Patient B] *was about 13 he*

understood what transgender was and as many of these young patients do, read extensively about it and understood exactly what this meant for him.'

422. The Tribunal also had regard to Dr S's reports. It noted that in paragraph 4 of his report of 18 December 2019, as set out above, he mentioned *'…physical and mental health history,..'* However, in his supplementary report dated 28 July 2021, Dr S states:

'ii. Pages 72 to 79 of the new information, entitled 'Child Psychological Questionnaire' documents further information about family structure; family health history; educational history; patient's physical and mental health history; learning disability; life events; substance use; gender identity and its development; patient's expectations of hormone therapy; resources and support available to the patient.'

423. He makes no further mention in his supplementary report that Dr Webberley did not obtain Patient B's mental health history.

424. The Tribunal was satisfied, on the evidence before it, that Dr Webberley had elicited information about Patient B's mental health history. It therefore found paragraph 3a(iv) of the Allegation not proved.

Paragraph 3

3. Following an initial consultation with Patient B on <u>or about</u> ~~11~~ <u>10</u> August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

a. obtain an adequate medical history for Patient B, in that you failed to elicit information about:

v. medication use;

425. Again, the Tribunal had regard to paragraph 4 of Dr S's report of 18 December 2019, as set out above.

426. The Tribunal noted in an email, dated 14 July 2016, from Dr Webberley's clinic to Patient B, it states:

*'Med hist ok?
Do you mind if I ask you some medical and personal questions? These will help me to offer you the most suitable treatment.'*

427. The Tribunal took into account that the questionnaire attached to the email of 14 July 2016 relates purely to Patient B's medical history and seeks to elicit such information. Question 10 states *'Do you currently take any medication'* to which Patient B responded *'No'*.

428. The Tribunal was satisfied that Dr Webberley did elicit Patient B's medication use. It therefore found paragraph 3a(v) of the Allegation not proved.

Paragraph 3

3. Following an initial consultation with Patient B on or about ~~11~~ 10 August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

a. obtain an adequate medical history for Patient B, in that you failed to elicit information about:

vi. smoking, alcohol and substance use;

429. Again, the Tribunal had regard to paragraph 4 of Dr S's report of 18 December 2019, as set out above.

430. The Tribunal had regard to the questionnaire sent to Patient B in which there is a question which states *'Have you ever taken part in any other risk taking behaviours (e.g. drugs, alcohol)'*

431. The Tribunal had regard to information about risks which was sent with the consent form to Patient B and noted that in paragraphs 6 and 7 it states:

'6. Taking testosterone can cause changes that increase the risk of heart disease; including:

- *Decreasing good cholesterol (HDL) and increasing bad cholesterol (LDL)*
- *Increasing blood pressure*
- *Increasing deposits of fat around the internal organs*

7. The risks of heart disease are greater if people in the family have had heart disease, if you are overweight, or if you smoke. The doctor can provide you with advice about options to stop smoking.'

432. The Tribunal notes that whilst there is reference to smoking in paragraph 7, this was not eliciting information about Patient B's medical history in relation to smoking. Rather, it was imparting information to the patient that the risk of heart disease when receiving testosterone may be potentiated by smoking. The Tribunal also had regard to Dr Webberley's letter to Patient B's GP, dated 15 August 2016. In this, Dr Webberley speaks, amongst other things, of Patient B's mental health issues and family history, but there is no mention of or any reference to 'smoking'. The Tribunal considered that the questions asked of Patient B in the Child Psychological Questionnaire, and given the content of Dr Webberley's letter to Patient B's GP, the information elicited by Dr Webberley related to alcohol and drugs, but not to 'smoking'.

433. The Tribunal therefore determined that Dr Webberley failed to obtain an adequate medical history in that she did not elicit information about smoking. Whilst the Tribunal acknowledged that this may have been in Dr Webberley's mind and possibly a 'live' issue, the Tribunal was not provided with any documentary evidence to support any assertion that Dr Webberley had elicited this information either by way of directly asking the question of Patient B or Patient B offering the information to Dr Webberley.

434. Dr Webberley's own information sheet explains why smoking is inadvisable during testosterone therapy. It follows therefore that not to elicit information from Patient B as to whether he smokes was a failing on Dr Webberley's part.

435. The Tribunal therefore found paragraph 3(a)(vi) of the Allegation proved in respect of Dr Webberley's failure to elicit information about smoking. It found paragraph 3(a)(vi) of the Allegation not proved in respect of Dr Webberley's alleged failure to elicit information about alcohol and substance use.

Paragraph 3

3. Following an initial consultation with Patient B on or about ~~11~~ 10 August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

a. obtain an adequate medical history for Patient B, in that you failed to elicit information about:

vii. forensic history;

436. Again, the Tribunal had regard to paragraph 4 of Dr S's report of 18 December 2019, as set out above.

437. The Tribunal acknowledged that a forensic history could assist Dr Webberley in establishing a profile for Patient B which could then help in considering whether any treatment was likely to be of benefit to him.

438. The Tribunal noted that Patient B did have a forensic history. On 9 February 2016, Patient B's mother had written an email to GIDS which included the following:

Patient B was born a girl but had been struggling with his identity for a while, which led to a few developmental problems which came about in adolescence: erratic behaviour, shop lifting, depression and self harm.

439. The Tribunal noted that when Dr Webberley wrote to Patient B's GP, having met Patient B on or about 10 August 2016, she made no mention of Patient B having a forensic history. Further, in her witness statement of 9 August 2021, Dr Webberley stated:

'There was no indication for me to take a forensic history from patient B as nothing in the history or on my observations indicated that there was any forensic involvement or difficulties.'

440. The Tribunal further noted that the questionnaires which were sent to Patient B and his mother in about July 2016 by Gender GP did not make enquiry of Patient B in sufficiently direct terms or in fact at all, whether he had any forensic history. Patient B never completed them in such a way as to disclose his forensic history.

441. In these circumstances, the Tribunal finds that Dr Webberley did not solicit information about Patient B's forensic history from Patient B or his mother. In the light of Patient B's email to GIDS, it finds that, had Dr Webberley made proper enquiry of Patient B and / or his mother, the information would have been forthcoming.

442. The Tribunal further finds that Dr Webberley should have made proper enquiry about Patient B's forensic history since such a history could assist her in regard to the treatment which she should prescribe for him.

443. The Tribunal therefore found paragraph 3a(vii) of the Allegation proved.

Paragraph 3

3. Following an initial consultation with Patient B on **or about** ~~11~~ **10** August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

b. arrange for Patient B to be **adequately** examined prior to prescribing testosterone treatment, including:
Amended under Rule 17(6)

i. a physical examination to determine:

1. blood pressure;

2. weight development;

444. The Tribunal determined that paragraph 3(b)(i) represents a misunderstanding by the GMC of Dr S's report. In his supplementary report, Dr S referred to:

NHS England's "Service Specification: Gender Identity Services for Adults (Non Surgical Interventions)"

which stated:

> *'Physical examination, other than the measurement of height, weight and blood pressure, must not be performed routinely during the assessment process. Examination of genitalia and chest is not a routine part of the assessment process. Physical examination may be recommended by the clinical team only if the individual's clinical history suggests that physical examination is likely to result in important benefit to the individual, or is likely to reduce an important risk of harm; or as a response to a specific request by the individual.'*

and he observed that:

> *'It is my understanding that no physical examination is performed by the assessing clinicians of the Tavistock Centre Gender Identity Development Service. Once they have endorsed a young person as ready to commence endocrine treatment, they are referred to a specialist Paediatric Endocrinology service with experience in providing care for those affected by gender dysphoria and it is in this setting that physical examination is undertaken. I know this from my reading of reports of other young people seen by the specialist Paediatric Endocrinology service that have subsequently sought transfer of their care to adult services and from discussion with Paediatric Endocrinologist colleagues on matters unrelated to these proceedings. In a young person who may not have completed pubertal development, physical examination was likely to reduce an important risk of harm, specifically harm that might arise from inappropriate pubertal induction. As it appears that Dr Webberley was the only clinician involved in [Patient B's] assessment, it would have been inappropriate for her to have personally examined [Patient B] as part of that assessment, but it was necessary for her to arrange for an examination by another medical practitioner. This was essential before recommending treatment with testosterone.'*

He added:

> *'An adequate examination, by her or by another medical practitioner, is not described in Dr Webberley's records. Important omissions from her record of the assessment include weight, blood pressure and the Tanner staging of [Patient B's] pubertal development, specifically the stage of their pubic hair growth and breast development. These data are essential for deciding on the appropriateness and timing of prescribing a GnRHa and testosterone.'*

445. Dr S was not stating that Dr Webberley was under a duty to arrange for Patient B to be examined by another practitioner in respect of blood pressure and weight development.

446. The Tribunal noted that paragraph 3(d) of the Allegation alleges that Dr Webberley failed to carry out these (as well as other) assessments herself prior to testosterone treatment. The Tribunal therefore dismisses paragraph 3(b)(i)(1) and (2) of the Allegation. It therefore finds them not proved.

Paragraph 3

3. Following an initial consultation with Patient B on **or about** ~~11~~ **10** August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

b. arrange for Patient B to be **adequately** examined prior to prescribing testosterone treatment, including:
Amended under Rule 17(6)

ii. a psychological assessment to:

1. confirm a diagnosis of gender dysphoria;

447. This paragraph of the Allegation is an echo of paragraph 1(b) of the Allegation in respect of Patient A. It advances the proposition that the psychological assessment should be undertaken by a person other than Dr Webberley. In particular, in respect of psychological assessment, it is based upon the expert report of Dr Q that no psychological assessment was offered to Patient B at any point by Gender GP and that there was no MDT assessment or input for Patient B. The Tribunal rejected the proposition that Dr Webberley was not competent to undertake a psychological assessment in respect of Patient A, and that she was obliged to obtain MDT input in respect of Patient A. It relies on that reasoning to reject Dr Q's opinion that she was under an obligation to arrange for another to undertake a psychological assessment of Patient B before prescribing testosterone.

448. Notwithstanding Dr Q's evidence, paragraph 3(b)(ii)(1) appears to allege that a diagnosis of gender dysphoria had been reached. The only medical practitioner who could have reached such a diagnosis was Dr Webberley, although she did not explicitly state that diagnosis in her letter to Patient B's GP drafted on 11 August 2016. Although Patient B's mother had sought a referral of Patient B to GIDS, and indeed he was seen at GIDS on 1 August 2016, the Tribunal understands that there had not been an assessment before Dr Webberley saw Patient B on or around 11 August 2016. Dr S in his expert report appears to acknowledge that Dr Webberley diagnosed Patient B. He wrote:

'It is possible that Dr Webberley appropriately diagnosed Patient [B]*, although this cannot be corroborated with the available records and documents.'*

449. The issue which he was considering was not whether Dr Webberley did or did not diagnose gender dysphoria, but whether that was an appropriate diagnosis. The Tribunal also noted that Dr G accepted the diagnosis of gender dysphoria, albeit in August 2017.

450. In her witness statement of 9 August 2021 Dr Webberley stated:

'I carried out a psychological assessment of Patient B and I confirmed the diagnosis. (Patient B) fulfilled the criteria for diagnosis of gender dysphoria, which is summed up in the guidance for GPs as found on [page 33/C5]:

> *'The International Statistical Classification of Diseases (ICD-10), published by the World Health Organization and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) offer the following diagnostic criteria: Gender Identity Disorder (DSM-IV) is a condition in which there is: "a strong and persistent cross-gender identification and a persistent discomfort with the sex or a sense of inappropriateness in the gender role of that sex".'*

451. The Tribunal noted that in July 2016, Dr Webberley had sent to Patient B and his mother the following consent form:

> PUBERTY BLOCKERS AND TESTOSTERONE THERAPY FOR UNDER 18 FTM WITH GENDER DYSPHORIA

452. It is apparent that at that stage, based upon the information she had received from Patient B's mother, Dr Webberley suspected that Patient B had gender dysphoria. The Tribunal considered that Dr Webberley's draft letter to Patient B's GP, properly construed, equates to the diagnosis of gender dysphoria which Dr Webberley maintains she reached following Patient B's visit to her on or around 11 August 2016.

453. The issue which paragraph 3(b)(ii) of the Allegation raises is whether Dr Webberley was obliged to have sought a second opinion to confirm her diagnosis of gender dysphoria. As mentioned, the Tribunal has found that Dr Webberley was competent to carry out a psychological assessment to arrive at a diagnosis. It finds that she did carry out that assessment and reached a diagnosis of gender dysphoria. The Tribunal therefore found that Dr Webberley was not under any obligation to arrange for Patient B to be examined by means of a psychological assessment to confirm her diagnosis of gender dysphoria. Paragraph 3(b)(ii)(1) is therefore found not proved.

Paragraph 3

3. Following an initial consultation with Patient B on or about ~~11~~ 10 August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

b. arrange for Patient B to be **adequately** examined prior to prescribing testosterone treatment, including:
Amended under Rule 17(6)

ii. a psychological assessment to:

2. consider alternative diagnoses;

454. This sub-paragraph of the Allegation concerns alternative diagnoses. Properly construed, the Tribunal reached the conclusion that this must refer to alternative diagnoses to gender dysphoria. The allegation appears to stem from Dr Q's report in which he stated:

> *'At the point that* [Patient B] *approached Gender GP no formal assessment of autism or gender dysphoria had been undertaken. Gender GP also did not offer a diagnostic process in line with the MDT approach laid out in WPATH or NHS 1180 service specifications.*
>
> > • *There was a failure to provide psycho-diagnostic assessment for alternative diagnoses before treatment'*

455. The Tribunal has already addressed the opinion advanced by Dr Q that Dr Webberley did not assess Patient B for gender dysphoria and that she was obliged to undertake an MDT approach. Here it is concerned with the issue of alternative diagnoses to gender dysphoria, although it may be thought that Dr Q was not in fact considering alternative diagnoses to gender dysphoria, but additional diagnoses to gender dysphoria. If the latter, the Tribunal considers them under paragraph 3(b)(ii)(3) below.

456. The Tribunal noted that the DSM criteria for Gender Dysphoria is a positive diagnostic scheme. It is not a differential diagnosis algorithm in which the practitioner must positively exclude alternative diagnoses that can present with the same signs and symptoms before reaching a conclusion. In the view of Dr Webberley, Patient B exhibited the criteria for Gender Dysphoria. She therefore diagnosed Gender Dysphoria. There was no place for an alternative diagnosis, nor any need for Dr Webberley to arrange for Patient B to be psychologically assessed to consider alternative diagnoses. The Tribunal therefore found paragraph 3(b)(ii)(2) not proved.

Paragraph 3

3. Following an initial consultation with Patient B on or about ~~11~~ 10 August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

b. arrange for Patient B to be **adequately** examined prior to prescribing testosterone treatment, including:
Amended under Rule 17(6)

ii. a psychological assessment to:

3. determine Patient B's mental health needs;

457. At the consultation with Patient B on or about 10 August 2016, Dr Webberley was aware that he had a number of psychiatric/behavioural issues which had given or were giving concern. He had overdosed on paracetamol in January 2016, and had a history of shop-lifting,

depression and deliberate self-harming (DSH). There is no evidence that Dr Webberley knew about the history of shop-lifting. She was aware that Patient B had been seen at CAMHS in 2015 and his mother had referred him to GIDS in early 2016 – the first and only appointment being on 1 August 2016. As mentioned, Dr Webberley diagnosed gender dysphoria, and treated Patient B accordingly. Dr Webberley was treating the principle presenting condition, something which may have had the effect of addressing, alternatively ameliorating all of Patient B's presenting signs and symptoms. She explained in her witness statement that she was able to do so as Patient B fulfilled the criteria for treatment set out in the Endocrine Society Guidelines 2009 which included the following criterion:

> (the patient does) '*not suffer from psychiatric comorbidity that interferes with the diagnostic work-up or treatment.*'

458. The Tribunal acknowledge that Dr W observed in his report as follows:

> *'There is nothing in the account of Patient B that gives me the impression he requires mental health support; rather, in his case, based on what he has written about himself, I would decide that of paramount importance is to commence him on testosterone treatment sooner rather than later, as the lack of testosterone treatment is the main cause of his distress and gender dysphoria.'*

459. Nevertheless, notwithstanding Dr W's view, the Tribunal was not satisfied that Dr Webberley determined Patient B's health needs in these other respects. It was possible that Patient B's other mental health needs, not in fact linked to his gender dysphoria, would not be addressed by the treatment which Dr Webberley prescribed for Patient B.

460. There is no evidence that Dr Webberley carried out an assessment, still less that she arranged for an assessment of Patient B's other mental health needs. She might for example have addressed these by observing to Patient B that those needs should be monitored to see if the treatment for gender dysphoria did achieve an holistic beneficial effect. The Tribunal therefore found paragraph 3(b)(ii)(3) proved.

Paragraph 3

3. Following an initial consultation with Patient B on <u>or about</u> ~~11~~ <u>10</u> August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

c. liaise with those who had previously provided care with regard to Patient B's mental health needs, including:

i. the Tavistock and Portman NHS Foundation Trust Gender Identity Development clinic ('the Tavistock');

461. Dr Webberley was made aware that Patient B had visited the Tavistock and Portman NHS Foundation Trust Gender Identity Development Clinic on 1 August 2016 as follows:

462. She was informed by his mother on 11 July 2016 (when she was first contacted) that:

> *'We are on a massively long waiting list for Gic;'*

and by Patient B in the consultation on or about 10 August 2016 that:

> *'… he eventually got referred to the Gender Clinic and he has been to see them once, but he is adamant that the treatment path that the NHS offers of blockers for a year followed by testosterone is really not right for him.'*

463. Dr Webberley explained in her witness statement that she did not feel the need to liaise with the Tavistock and Portman Clinic as Patient B was going to wait until he could be transferred to adult services, and in the meantime seek therapy from Dr Webberley. In fact, Patient B did not receive any care from the Tavistock and Portman Clinic with regard to his mental health needs. The Tribunal therefore find paragraph 3(c)(i) not proved.

Paragraph 3

3. Following an initial consultation with Patient B on or about ~~11~~ 10 August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

c. liaise with those who had previously provided care with regard to Patient B's mental health needs, including:

ii. Patient B's private therapist;

464. Following Patient B's mother's approach to Gender GP on 11 July 2016, Ms II, the Clinic Manager, advised her that ongoing costs could include face to face counselling sessions with a local counsellor. Dr P noted that Patient B's mother answered a question from Dr Webberley's clinic enquiring whether Patient B had had 'counselling as yet' in the affirmative on 21 October 2016. In an email to the GMC dated 7 December 2017, Dr SS confirmed that Patient B did have counselling with one of Gender GP's 'highly trained counsellors'.

465. It appears that this allegation stems from Dr Q's understanding that there was a counsellor who was providing therapy for Patient B at the time when Dr Webberley prescribed testosterone for him. However, that counsellor was part of the service which Gender GP provided to Patient B and was not doing so independently of her.

466. In her witness statement Dr Webberley observed that she had recorded in her letter to the GP dated 11 August 2016:

'He has support from his family and friends and a local LGBT group. He has a family friend who is a Samaritans counsellor who offers him a great deal of support and he feels 100% as his family do of his conviction that masculinisation therapy is the right thing for him.'

467. Notwithstanding Dr Webberley's mention of the family friend, the Samaritan's counsellor, the Tribunal did not conclude that this was the person to which paragraph 3(c)(ii) referred. It is most unlikely that such a person would be regarded as Patient B's private therapist.

468. In the circumstances, the Tribunal concluded that Dr Q's understanding that there was an independent private therapist offering Patient B counselling was mistaken. In the circumstances, the Tribunal finds paragraph 3(c)(ii) not proved.

Paragraph 3

3. Following an initial consultation with Patient B on or about ~~11~~ 10 August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

c. liaise with those who had previously provided care with regard to Patient B's mental health needs, including:

iii. the Child and Adolescent Mental Health Services team;

469. Patient B had been seen by CAMHS in the summer of 2015. By reason of his non-attendance and lack of engagement, CAMHS closed their file on Patient B on 27 June 2016 because he had long since ceased to engage with them. They were not providing care for Patient B when he consulted with Dr Webberley in August 2016. In her witness statement, Dr Webberley wrote:

'I did not liaise with CAMHS as I was able to elicit all the information I needed from my assessments. Patient B had told me that CAMHS were not experienced in gender dysphoria. '

470. In her letter to the GP dated 11 August 2016 Dr Webberley recorded:

'He tells me he had a terrible experience with CAMHS where they were trying to diagnose him as being autistic because his mother works with children with autism and did not want to recognise the gender issues.'

471. The Tribunal did not consider that Dr Webberley was under any duty in these circumstances to liaise with CAMHS. It therefore found paragraph 3(c)(iii) not proved.

Paragraph 3

3. Following an initial consultation with Patient B on or about ~~11~~ 10 August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

d. conduct an adequate assessment of Patient B prior to testosterone treatment, including eliciting details of:

i. height;
ii. weight;

472. The Tribunal considered these paragraphs together.

473. The Tribunal noted that at paragraph 4b of his report, dated 18 December 2019, Dr S stated *'Important omissions from her record of the assessment include height, weight, blood pressure'*.

474. The Tribunal had regard to the medical questionnaire completed by Patient B and it noted that in response to question 6 *'Your height'*, Patient B stated *'5 ft 8"'*. In the same questionnaire, in response to question 7 'Your weight', Patient B stated '138lb'. The Tribunal was therefore satisfied that Dr Webberley was aware of Patient B's height and weight prior to testosterone treatment.

475. The Tribunal noted, however, that as the questionnaire was completed by Patient B in July 2016, it was some 3 months before he was started on testosterone on 26 October 2016. It was the Tribunal's view that Dr Webberley should have obtained Patient B's height as a baseline immediately prior to starting him on testosterone. For these reasons, the Tribunal determined that Dr Webberley failed to elicit his height prior to testosterone treatment. Further, the Tribunal took into account that in contrast to the situation in respect of Patient A, Patient B was not on GnRHa medication in the period between the initial assessment of his height and weight and the initiation of testosterone treatment. It was therefore more of a possibility that Patient B could experience a growth spurt in the period before the inception of testosterone treatment.

476. In the circumstances, it was the Tribunal's view that Dr Webberley should have obtained Patient B's height and weight as a baseline immediately prior to starting him on testosterone.

477. For the reasons set out above, the Tribunal determined that Dr Webberley failed to elicit Patient B's height and weight prior to testosterone treatment. It therefore found paragraphs 3(d)(i) and (ii) of the Allegation proved.

Paragraph 3

3. Following an initial consultation with Patient B on or about ~~11~~ 10 August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

d. conduct an adequate assessment of Patient B prior to testosterone treatment, including eliciting details of:

iii. blood pressure;

478. The Tribunal had regard to paragraph 4b of Dr S's report, as set out above.

479. It noted that, in the undated questionnaire completed by Patient B, in response to question 11: *'Do you have a recent blood pressure reading'*, Patient B stated *'No'*.

480. In her witness statement of 9 August 2021, Dr Webberley states in relation to this:

'Patient B was asked if he had had a recent blood pressure reading and he had not. His further management would not have been affected by a blood pressure reading and it was not indicated to take one. He was a fit and healthy 16 year old boy and blood pressure is not affected by the addition of testosterone to his hormone profile.'

481. The Tribunal has found several references where it is stated that blood pressure should be considered or taken prior to prescribing testosterone:

- At paragraph D11.2 of the document entitled 'Guidance for GPs, other clinicians and health professionals on the care of gender variant people' dated 10 March 2008 under the heading 'Monitoring suggestions' it is stated:

'Baseline: initially, record weight, height, blood pressure and urine tests; full blood count; liver and renal function; lipid profile; thyroid-stimulating hormone; prolactin; fasting glucose; luteinising hormone; follicle-stimulating hormone; oestradiol and testosterone; and clotting screen. Further checks after start of treatment at approximately:

- In the 'Guidelines on the Endocrine Treatment of Transsexuals J Clin Endocrinol Metab, September 2009' at paragraph 4.1 headed 'Evidence', it is stated:

'Pretreatment screening and appropriate regular medical monitoring is recommended for both FTM and MTF transsexual persons during the endocrine transition and periodically thereafter (13, 97). Monitoring of weight and blood pressure, directed physical exams, routine health questions focused on risk factors and medications, complete blood counts, renal and liver function, lipid and glucose metabolism should be carried out.'

- In the same document under 'Risk Assessment and Modification for Initiating Hormone Therapy' in the same document, it is stated:

  'All assessments should include a thorough physical exam, including weight, height, and blood pressure.'

482. Notwithstanding Dr Webberley's position, which was endorsed by the evidence of Dr W, the Tribunal was satisfied that she did have an obligation to arrange for a physical examination of Patient B to ascertain his blood pressure before prescribing testosterone. She did not do this. The Tribunal therefore finds paragraph 3(d)(iii) of the Allegation proved.

Paragraph 3

3. Following an initial consultation with Patient B on or about ~~11~~ 10 August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

d. conduct an adequate assessment of Patient B prior to testosterone treatment, including eliciting details of:

iv. Tanner staging of Patient B's pubertal development, including stages of:

1. pubic hair growth;

2. breast development;

483. The Tribunal considered paragraphs 3(d)(iv)(1) and (2) together.

484. The Tribunal understands that this allegation arises from Dr P's report in which he stated:

'The decision on GAH dosage scheme is now also based on clinical factors such as Tanner stage at start GnRHa, duration of GnRHa monotherapy, body size and psycho-social factors. Generally, GnRHa started in early puberty the go low and slow dosage and when started in late puberty, the more rapid dosage. Since timing of start GAH and the dosage scheme of GAH depend on many somatic and psycho-social factors these issues need to be discussed during the MDT meeting to decide on the most optimal treatment regime.'

485. He does not precisely deal with the situation whereby GAH is being prescribed without there having first been prescribed GnRHa. However, it may be discerned that Tanner stage is an important matter for the physician to consider; one which the physician ought to consider. Of course, the Tribunal noted Dr S's observation (to which reference was made when considering paragraph 3(b)(i)(1) and (2) above) that it would not have been appropriate

for Dr Webberley to have carried out a physical examination of Patient B. In his report, Dr W expressed the following view:

> *'I am of the opinion that a physical examination of breasts and genitalia in such 16 or 17 year old trans adolescents is completely inappropriate for a trans health specialist and causes a high level of distress and discomfort to young people.'*

486. Paragraphs 3(d)(iv)(1) and (2) refer to an assessment, not an examination.

487. When Dr Webberley saw Patient B in August 2016, he was 16 years and 3 months old. He told her:

> *'There is nothing left to block'*

488. When she prescribed testosterone he was 16 years and 6 months. In her witness statement, Dr Webberley states:

> *'Patient B was post-pubertal and examination of pubic hair and breast development was not indicated and would not have altered the management plan. Puberty started prior to the age of 13.'*

489. The Tribunal determined that, in the context of his being present at the consultation, Dr Webberley made sufficient enquiry of Patient B to establish that the Tanner staging of Patient B of pubertal development. It therefore found paragraphs 3(d)(iv)(1) and (2) of the Allegation not proved.

Paragraph 3

3. Following an initial consultation with Patient B on **or about** ~~11~~ **10** August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

e. obtain informed consent in that you failed to ascertain:

i. how Patient B had reached the decision to agree to his treatment plan;

ii. whether Patient B understood the long term risks of the treatment proposed;

490. The Tribunal considered paragraphs 3(e)(i) and (ii) together.

491. This allegation is based on Dr P's report. He stated in answer to questions 12 and 13 set out below:

*'12. Did Dr Webberley obtain consent for each separate stage of the treatment?
On July 16, 2016 an informed consent form for the start of testosterone was sent to the family but a signed copy was not provided in the file. Whether informed consent was obtained for the use of GnRHa is not documented. The SOC7th differentiates between fully reversible and partly reversible hormonal treatment options. Puberty blockers (GnRHa) fall in the first category and testosterone falls in the second. [Patient B] started on testosterone, thus informed consent counselling on this topic, discussing the irreversible effects (e.g. breaking of the voice) and partially reversible effects (hair growth, fertility) is of utmost importance. The GnRHa was later added as an adjuvans and not as main therapy. In my opinion a very extensive counselling which is appropriate when starting only on GnRHa (GnRHa monotherapy) was in this case not necessary.
13. Did Dr Webberley (appear) to consider and assess that the patient had the capacity to make decisions about their treatment?
In HW's report she states that [Patient B] was 100% fully on board to start the treatment and therefore he agrees with the therapy. However, how he had come to make this decision and whether he fully oversees the (long term) implications is not documented. The process does not meet the adequate level of care as outlined in SOC7th.'*

492. It is to be noted that Dr P did not have the copy of the consent form signed by both Patient B and his mother in the documents which he perused. The same seems to be true of Dr Q, who wrote in answer to his question 12:

*'12.Did Dr Webberley obtain consent for each separate stage of the treatment?
Point 6 of GMC guidance on Decision Making and Consent:*

*"Obtaining a patient's consent needn't always be a formal, time-consuming process. While some interventions require a patient's signature on a form, for most healthcare decisions you can rely on a patient's verbal consent, as long as you are satisfied they've had the opportunity to consider any relevant information (see paragraph 10) and decided to go ahead.
Although a patient can give consent verbally (or non-verbally) you should make sure this is recorded in their notes.*"
Dr Webberely (sic) does write that she fully explained the nature of the provided treatment in her letter to the GP dated 11th August 2016. However, I can see no consent forms in the documentation available to me.*

- *There was a failure to obtain written consent which is an essential requirement before undertaking any treatment.*
- *This is inadequate practice.'*

493. The Consent form for Under 18 year olds was sent to Patient B and his mother on 16 July 2016, some two weeks before the consultation on 1 August 2016. The administrative staff reminded Patient B about signing the consent form on 11 August 2016. It was returned signed on 6 September 2016. The Consent form is both a patient information sheet and a

consent form. It lists possible long-term considerations and risks of testosterone use in genetic females. When signed the patient states:

> *'My signature below confirms that:*
> - *My doctor has talked with me about the benefits and risks of puberty blockers and testosterone, the possible or likely consequences of hormone therapy, and potential alternative treatment options.*
> - *I understand the risks that may be involved.*
> - *I understand that this form covers known effects and risks and that there may be long-term effects or risks that are not yet known.*
> - *I have had sufficient opportunity to discuss treatment options with my doctor. All of my questions have been answered to my satisfaction.*
> - *I believe I have adequate knowledge on which to base informed consent to the provision of puberty blockers and testosterone therapy.'*

494. The Tribunal does not suggest that a signed consent form necessarily puts an end to any concerns as to whether a patient was indeed consenting to the treatment which being offered. However, the fact that there is a signed consent form addresses one concern of Dr P and Dr Q.

495. Further, in this case, the Tribunal has the benefit of Dr Webberley's letter to the GP in which she summarises Patient B's history as a transgender youth and how he came to a decision to transition. He was already self-educated. He stated in answer to the following questions posed in the Child Psychological Questionnaire which he completed for Dr Webberley:

> *'How old were you when you first experienced the feeling of gender? How did you feel and why do you think you are gender dysphoric?*
> *I was 14 when I first found out what transgender meant, and gradually over a few months I applied that to myself and realised that I was transgender as I recognised feelings of dysphoria in myself. So it was 14 when I realised what it was I was feeling but I had experienced a disconnect between my sex and my gender for a long time before that. Initially I felt relieved as I had a name as to what it was I was feeling (dysphoria) but it developed into frustration as I realised how convoluted the process of changing gender and getting cross sex hormones is. Now, I think I am gender dysphoric as I cannot think of myself as a female anymore – having been out as male for the last year openly – and I experience massive amounts of distress over the fact I have to bind my chest, still get my period and still get seen as female by some people. Now that I feel more confident in my identity the dysphoria I experience has increased as my body is the opposite of who I am and who I want to be.'*

496. Further, in the Child Psychological Questionnaire, Patient B also stated:

> *'I am involved with organisations such as The Proud Trust in Manchester which provide support for LGBT+ young people like myself. I have quite a few friends who*

identify as trans or non-binary. In the future I want to be involved and support the trans community – however I don't want it to be the defining thing about me like it is now. For instance, when I meet new people I have to tell them I'm transgender as otherwise they assume I'm female – in the future I don't want this to be the first thing people know about me and I'd like to be known more as just the "trans friend" which is how I feel I am right now.'

497. Moreover, Dr Webberley also noted in the letter that she had discussed with Patient B and the mother of Patient B the pros and cons of GAH therapy.

498. In her witness statement, Dr Webberley wrote:
'It was clear from the history that I attained that Patient B had a long-standing and insistent gender identity that differed from the sex he was assigned at birth. He and his mother had researched the options available to him and had looked at the various protocols available for his care. He informed me that the protocol for the Tavistock to have blockers for a year before being referred on to adult services would feel too long to wait for him. He felt that 'there was nothing left to block'. His preferred management plan was to start masculinising therapy directly and he and his mother and I were all in agreement.'

499. In the light of the foregoing, the Tribunal has determined that Dr Webberley did obtain informed consent in that it was plain to her how Patient B had reached the decision to agree to his treatment plan and that he understood the long term risks of treatment proposed. Paragraph 3(e) is therefore found not proved.

Paragraph 3

3. Following an initial consultation with Patient B on **or about** ~~11~~ **10** August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

f. adequately assess Patient B's capacity to consent to treatment;

500. This allegation appears to stem from Dr Q's report. He wrote:

'There is no indication of a formal assessment of capacity in the documents that I have been provided. There is also no statement of capacity or indication that capacity assessment was conducted. This is concerning as capacity is known to fluctuate and the nature of the treatment would, as outlined previously, require a formal documentation.

• There was a failure to administer the practice guidance of the Mental Capacity Act (2005) Code of Practice.
• This is an inadequate standard of

Please identify whether there was any information available to Dr Webberley which raised a question as to whether the patient had:

a. …

b. capacity to make decisions about their treatment?

… However, there may have been cause to question capacity that may not have been clear to Dr Webberley as no contact had been made with previously involved services regarding the following issue:

[Patient B] *was suspected to meet criteria for a diagnosis of autism, and without this diagnosis being fully explored it would not be possible to include or exclude this from his overall formulation. As decisions about gender confirming treatment are based, at least in part, on this formulation* [Patient B] *cannot be said to have been in command of all the relevant information in order to 'weigh up' options prior to a decision. As the refusal to undertake autism assessment or full Tavistock GIDS assessment could be seen to be contradictory to* [Patient B]*'s expression of need for support, it would be possible that this seemingly irrational refusal could be attributable to autistic rigidity, or intense anxiety from the underlying factors that contributed to DSH (Deliberate Self Harm). In that regards* [Patient B] *could be said to have not had the capacity to consent to the decision to start testosterone, as he had declined important assessment which could have informed that decision based on the effects of a disorder of the mind (autism or anxiety).*

There was cause to formally assess capacity and pursue the incomplete assessment for autism spectrum condition before accepting consent.

- *There was a failure here to investigate possible factors that may have had an effect on capacity to consent to treatment.*
- *This is an inadequate standard of care.'*

501. The Tribunal noted Dr S's observation that:

'There is no information in the records and documents provided that would suggest to me that Patient (B) lacked capacity to consent to the interventions provided including endocrine interventions.'

502. It also noted Dr W's observation in his report:

'If the patient comes across as intelligent and articulate and able to provide a sensible narrative (see for evidence for instance the Child Questionnaire patient B has filled out) I would assume that patient has the capacity to consent, as they will be able to understand the role of treatment and consent to the treatment that is offered. Unless there are unusual circumstances, where capacity to consent is in doubt, it is not common practice to record this; rather, I would record capacity to consent if I thought it was impaired to any degree.'

503. The Tribunal accepted that capacity to consent is a matter which must be assessed in respect of every patient and every decision. The question for the Tribunal is whether Dr Webberley did assess Patient B's capacity. In her witness statement, Dr Webberley wrote:

> *'The clinic appointment where we discussed the effects in full was on 11/08/2016. 'Patient B, his Mother and myself all discussed the request for this treatment, and the pros and cons of such a course of action and informed consent was obtained both verbally and in writing. 'he feels 100% as his family do of his conviction that masculinisation therapy is the right thing for him. I have fully discussed the pros and cons and side effects and fertility, sex and Patient B is 100% on board with continuing his quest to start testosterone treatment and does not wish to preserve and fertility.' [Page 483/C4b].*
>
> *When discussing consent to treatment, and reviewing his written and verbal communication skills, I noted no concerns in his capacity to understand and retain information and to make difficult decisions.'*

504. At the material time, Patient B was well over the age of 16. The Tribunal accepts that Dr Webberley did not directly address in documentary form the issue of capacity. It noted that the same was in fact true in GIDS documentation. It finds that she ought to have done. The Tribunal was mindful of the fact that it is for the GMC to prove to the requisite standard – the balance of probabilities – the allegation. It has reached the view that the GMC has not proved to its satisfaction on that standard that Dr Webberley did not adequately assess Patient B's capacity to consent to the treatment.

Paragraph 3

3. Following an initial consultation with Patient B on or about ~~11~~ 10 August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

g. in the alternative to Paragraph 3f, record any assessment of Patient B's capacity to consent;

505. The Tribunal noted Dr S's oral evidence in this regard. He stated that transitioning is a significant life-altering course of treatment and, as such, he would expect that a doctor would record their capacity assessment, if for no other reason than to provide a defence is there is a criticism later on.

506. The Tribunal accepted that Dr Webberley was under an obligation to record any assessment of Patient B's capacity to consent. Whilst it has reached the conclusion that she did in fact assess that capacity, it was only able to do so in the light of the evidence which told on the issue. More properly, she should have recorded that assessment directly in the documentation. It therefore found paragraph 3(g) proved.

Paragraph 3

3. Following an initial consultation with Patient B on or about ~~11~~ 10 August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

h. provide adequate follow-up care to Patient B after initiating treatment in that you failed to arrange review consultations;

507. Paragraph 3(h) is expressed in the plural. It does not simply refer to a first review consultation. It appears to stem from Dr S's report. He stated:

'Dr Webberley did not arrange adequate and appropriate follow up care for Patient (B). A reasonably competent General Practitioner with a special interest in gender care and sexual health at that time would have provided a review consultation a few weeks after initiation of testosterone therapy, in order to assess its bio-psycho-social impact and any adverse effects. A reasonably competent General Practitioner with a special interest in gender care and sexual health at that date would have arranged subsequent review consultations.'

508. Dr S was not precisely supported in this regard by Dr P who was concerned that there should be regular (3 – 6 monthly) biological checks principally blood tests. In his report Dr W observed:

'Dr Webberley organised blood investigations to be carried out in January 2017 after Patient B started on testosterone at the end of October 2016. At the Nottingham Centre for Transgender Health we do exactly the same: we organise blood investigations and a follow up after approximately 3 months that the patient commenced cross-sex hormone treatment.'

509. The Tribunal noted that there was post-GAH follow up concerning blood tests, which broadly conformed with Dr P's expectations. However, no consultations were initially offered. Patient B wrote to Dr Webberley on 5 January 2017 in the following terms:

'To XXX
Increasing T dosage?
Hello, i'm a 16 year old transman who had an appointment with you over the summer and managed to get a bridging prescription (thank you!) of testosterone gel which i started in late october. i've been on a prescription of half a sachet of gel per day since, and am set to be on that until February. in the appointment it was discussed that I would start out on a lower dosage of T for the first few months and then the dosage would be increased; i was wondering if this is still happening? is there any chance my prescription could be altered to testosterone shots, or to a whole sachet of T per day? i realise you probably won't remember who i am so if you get this email could you reply to:

(my mum's email who has been corresponding with you)
thank you :)'

510. This elicited the following response from Dr Webberley's clinic manager on 11 January 2017:

'Hi there
In order to adjust the prescription we will need to have some up to date blood tests. There are several options for the tests:

1) …
2) …
3) …

Please be aware that if the blood sample gathered with the home kit is damaged there will be a £30 retesting fee per test required. Instructions to avoid this will be sent with the test. Please let us know which is the preferred option.
Best wishes …..'

Then on 24 January 2017, following blood tests being undertaken, Dr Webberley's Administrative Assistant wrote to Patient B's mother

'Hi , Thank you for sending those results through. I will pass these over to Dr Webberley to assess. In the meantime can you please confirm any physical or psychological changes noticed by [Patient B] *since starting treatment?*
Best wishes, '

And received this reply in the same day:

'Dear [….],
From my own perspective [Patient B] *has become more temperamental, he's become more prone to actually saying what is wrong rather than internalising, which may be a product of the testosterone or simply his character. I actually prefer it simply because he's not being quiet about it and is actually communicating. He has mentioned some feelings which have taken him by surprise in that they've been quite violent towards himself, more in the nature of compulsive feelings, and I think he recognised that he wasn't feeling like this before the testosterone. But he has reassured me that they have been mild compulsive feelings. In general though he is very happy about being on it as it signifies to him that he is transitioning and something is actually happening compared to the years of waiting, which to be honest was doing him more harm. He could probably do with a phone interview so he can talk through some of these feelings with you in more detail.'*

Dr Webberley responded on 27 January 2017 as follows:

'Dear, Many thanks for sharing your thoughts about [Patient B] . I am more than happy to have a chat with him on the phone and of course you are more than welcome to come and see me in my clinic to talk through some of these things. The

testosterone level in his blood test is really very good so I am pleased about that. Dare I ask about periods and things like that, have they stopped?
I look forward to hearing from you.
Best wishes,
Dr Webberley'

And then on 30 January 2017, Patient B's mother sent a lengthy "word document" from Patient B as follows:

'For your information Dr. [Patient B] has written about the changes which he has experienced:
Since starting testosterone on the 29th October I have noticed definite (if gradual changes) beginning to occur. In terms of psychological changes in the first month my appetite was massively increased and I had quite emotional mood swings, and intrusive thoughts – this stopped after a month of the treatment. A massive amount of my anxiety also decreased due to the treatment, probably as the thing I've needed for the last three years is finally happening. In terms of physical changes I have only noticed these really beginning to happen in the last month or so; I have started growing thicker and darker hair on my legs and arms, and have noticed spiky hairs on my chest and face. My face has slightly changed in shape to become squarer and longer (I'm told) and I have a more defined jawline; my neck has also become slightly thicker and I am sure I'm beginning to grow an Adams apple. I've lost some weight in my legs and my torso has a more "masculine" shape i.e not such a defined waist. The physical changes that haven't occurred in my mind greatly outweigh the changes that have occurred; I still get my periods and my voice has not dropped. Even though my body has started changing more rapidly in the last month I still regularly get misgendered (called she/a girl) because the changes are still very minimal, and I can only notice them because I'm looking for them. As of how I want to move forward with the treatment, I think it would be best for me if I was to move on to the testosterone injections. Whilst the gel is useful and I'm grateful for the changes that have happened so far I feel that to continue with it would prolong the changes testosterone brings unnecessarily; since I have been waiting for testosterone since 2014 it is somewhat frustrating to be on such a low dosage and to know the changes will be slower than what is usual. Also, it is a practicality issue: I apply the gel in the morning before I get the train to college, and because the train I get is so early and things are often hectic in the morning getting to the station it is easy to forget to apply it (this has happened five or six times now). This means I have to apply it in the evenings when I get back, which I think leads to an uneven level of hormone in my bloodstream as the routine of applying it gets disrupted; if I was on the injections then this would not be an issue.'

To which Dr Webberley responded on 31 January 2017 as follows:

'Hi (Patient B),
thank you for your message which had some good and some bad. I think it would be best if you had the puberty blocking injections as these will drop your oestrogen and

allow the testosterone to work better. Would this be possible? We could then also swap to the injections for T as well. The one big question is who will actually prescribe and give the injection? Will your GP be happy to do this under my supervision, in that way the NHS pays for it? If not then you have to buy the injections privately and they are about £100 per month, and we have to find someone to actually give the injection (a nurse or doctor or me). What are your thoughts on this?
Dr Webberley'

511. The Tribunal considered that the matters which were being raised with Dr Webberley by Patient B and his mother in January 2017 demonstrated the need for there to be regular review consultations as indicated by Dr S. It found that she had an obligation to provide adequate follow-up care to Patient B including arranging review consultations.

512. The Tribunal did not find that Dr Webberley was in breach of this obligation in not having arranged a review consultation in January 2017 as, in fact, she suggested such a consultation. However, the Tribunal noted that the stimulus for such a consultation did not come from Dr Webberley but from Patient B and / or his mother.

513. As set out in the response by Dr Webberley dated 31 January 2017, she determined to add GnRHa to Patient B's prescription. Notwithstanding that change, Dr Webberley did not arrange any further consultations with Patient B. The Tribunal found, based on Dr S's report, that she was under an obligation to do so, and all the more so as there was a change in prescription and because that change did not accord with the wishes of Patient B as expressed on 5 January 2017. The Tribunal therefore found paragraph 3(h) proved.

Paragraph 3

3. Following an initial consultation with Patient B on or about ~~11~~ 10 August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

i. provide the correct change to Patient B's prescription when he reported continued menstruation in that you:

i. failed to prescribe a step-up dosage of testosterone;

ii. inappropriately prescribed Gonadotropin-releasing Hormones ~~('GnHRa')~~ (GnRHa); **Amended under Rule 17(6)**

514. The Tribunal considered paragraphs 3i (i) and (ii) together.

515. This allegation stems from Dr P. He expressed the view, which the Tribunal accepted, that the dosage of testosterone - 25 mg testosterone gel transdermally once a day - prescribed by Dr Webberley on 26 October 2016 was a stepping up dosage i.e. an initially low dosage which after a suitable interval would be increased. He then stated:

'From an endocrine point of view, given the fact that [Patient B] *was still on the 'stepping' dosage, the most logical step would be to increase the dosage to an adult maintenance dosage of 50 mg to increase the rate of virilization and to suppress menses. However, HW proposed to add a GnRHa, which will of course stop menstruation but not likely increase virilization rate.'*

516. However, in the same report he also stated:

'It is recommended in the Endocrine Guidelines (2009) to increase the dosage of testosterone in the late pubertal transgender adolescent after 6 months of start dosage (step-up dosage). The addition of GnRHa does not meet the recommended level of a care.'

517. As Patient B had started the step up dose of testosterone in late October 2016, six months had not elapsed by the time Dr Webberley prescribed in addition GnRHa on 31 January 2017. When this was pointed out to Dr P by a member of the Tribunal, and that Patient B was reporting continued menses when he was asking for increased testosterone, Dr P conceded that Dr Webberley's approach of a slow step up protocol was correct and followed the guidelines.

518. Dr Webberley explained her approach as follows in her witness statement:

'Patient B was prescribed Testogel which in some patients is effective in suppressing the menstrual cycle. However, for Patient B this was not the case and he continued to have periods. There are two approaches, either to increase the testosterone, or to add in another agent to suppress the ovarian hormone cycle. As this patient was early in his masculinisation regime, it was not indicated to increase testosterone yet, that took place later. 'Once we are stable with the Tesogel (sic) then I suggest we change to testosterone injections as well.

The best way to suppress the ovarian hormone cycle is to use GnRH agonists. I understand that Dr P has suggested that progestins may have been a more appropriate prescription, however I disagree for this patient.

I know that some protocols were advising GPs to prescribe progestins as a way to suppress menses in patients who were experiencing distress with their monthly menses. However, I was mindful of concerns about this medication. 'In high doses, progestins are relatively effective in suppression of menstrual cycling in girls and women and androgen levels in boys and men. However, at these doses, side effects such as suppression of adrenal function and suppression of bone growth may occur.' The WPATH Standards of Care at [page 173/C5] state that: 'Adolescents with female genitalia should be treated with GnRH analogues, which stop the production of estrogens and progesterone. Alternatively, they may be treated with progestins (such as medroxyprogesterone).'

The Endocrine Society guidance found on … 'We recommend that GnRH analogs be used to achieve suppression of pubertal hormones.'
'Hormone therapy

If your child has gender dysphoria and they have reached puberty, they could be treated with gonadotrophin-releasing hormone (GnRH) analogues. These are synthetic (man-made) hormones that suppress the hormones naturally produced by the body. Some of the changes that take place during puberty are driven by hormones. For example, the hormone testosterone, which is produced by the testes in boys, helps stimulate penis growth.

As GnRH analogues suppress the hormones that are produced by your child's body. They also suppress puberty and can help delay potentially distressing physical changes caused by their body becoming even more like that of their biological sex, until they are old enough for the treatment options discussed below.
GnRH analogues will only be considered for your child if assessments have found that they are experiencing clear distress and have a strong desire to live as their gender identity. The NHS website advice at the time was ''The effects of treatment with GnRH analogues are considered to be fully reversible, so treatment can usually be stopped at any time.'

519. The Tribunal found this to be a full and impressive answer to the Allegation set out in paragraph 3(i). Dr W also gave evidence which assisted the Tribunal in this regard. He said in his report:

'There are 4 options available if a trans male patient reports that their periods continue. You can choose to wait and see, particularly in the early stages of treatment, when the menstrual cycle is not adequately suppressed (yet). Secondly, one could opt to prescribe a progestins to suppress a patient's period, but in my experience, most trans men do not want more "female hormones" in their body. A third option would be to increase the testosterone dosage, but given that Patient B's testosterone level was 18.2 nmol/L I would be reluctant to go for this option; also, because in my experience if you increase the testosterone dosage too fast you increase the risk of developing polycythaemia, which may predispose patients to adverse vascular events. The fourth and final option is to introduce a GnRH analogue to stop the production of estrogens and progesterone. It is a safe, quick and effective way to cease the menses, particularly if patients are very distressed by their menses. In my experience, the last option is what we mostly practise in Nottingham.'

520. In the circumstances, the Tribunal finds paragraphs 3(i)(i) and (ii) not proved.

Paragraph 3

3. Following an initial consultation with Patient B on <u>or about</u> ~~11~~ <u>10</u> August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

j. engage in and / or with an adequately trained and specialist multidisciplinary and interdisciplinary team, in that you did not seek input before and during treatment from a:

i. paediatric endocrinologist;

ii. mental health practitioner.

521. The Tribunal considered paragraphs 3(j)(i) and (ii) together.

522. The Tribunal was mindful that paragraphs 3(j)(i) and (ii) of the Allegation, which relate to Patient B, are expressed in similar terms to paragraphs 1(l)(i) and (ii) of the Allegation, which relate to Patient A. The patients are different, but the principles which the Tribunal considered and upon which it relied in order to reach its determination are the same. Insofar as the reasoning in its determination in respect of paragraphs 1(l)(i) and (ii) of the Allegation is not exclusive to Patient A, the Tribunal relies upon it in relation to paragraphs 3(j)(i) and (ii).

523. Further the Tribunal relies upon its determination at paragraph 4(b) below.

524. The Tribunal therefore finds paragraphs 3(j)(i) and (ii) not proved.

Paragraph 4

4. In treating Patient B as set out at paragraph 3 above, you:

a. failed to adhere to the following professional guidelines:

i. Endocrine Society Professional Guidelines (2009);

ii. World Professional Association for Transgender Health Standards of Care (7th Edition);

525. The Tribunal considered paragraphs 4(a)(i) and (ii) together.

526. The Tribunal was mindful that paragraphs 4(a)(i) and (ii) of the Allegation, which relate to Patient B, are expressed in similar terms to paragraphs 2(a)(i) and (ii) of the Allegation, which relate to Patient A. The patients are different, but the principles which the Tribunal considered and upon which it relied in order to reach its determination are the same. Insofar as the reasoning in its determination in respect of paragraphs 2(a)(i) and (ii) of the Allegation is not exclusive to Patient A, the Tribunal relies upon it in relation to paragraphs 4(a)(i) and (ii).

527. It therefore finds paragraphs 4(a)(i) and (ii) of the Allegation not proved.

> b. knew or ought to have known you were acting outwith the limits of your competence as a General Practitioner with a special interest in gender dysphoria.

528. The Tribunal was mindful that paragraph 4(b) of the Allegation, which relates to Patient B, is expressed in similar terms to paragraph 2(b)of the Allegation, which relates to Patient A. The patients are different, but the principles which the Tribunal considered and upon which it relied in order to reach its determination are the same. Insofar as the reasoning in its determination in respect of paragraph 2(b) of the determination is not exclusive to Patient A, the Tribunal relies upon it in relation to paragraph 4(b).

529. It therefore finds paragraphs 4(b) of the Allegation not proved.

<u>Patient C</u>

Paragraph 5

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

> a. did not arrange for Patient C to be **<u>adequately</u>** examined prior to prescribing ~~testosterone and GnHRA~~ <u>GnRHa</u> treatment, including:
> Amended under Rule 17(6)
>
> > i. a physical examination to determine:
> >
> > 1. Bone health

530. This allegation appears to stem from Dr P's report in which, referring to the follow-up protocol for pubertal suppression in the Endocrine Society Guidelines 2009, he states:

> *'… Bone density using dual-energy x-ray absorptiometry must be determined to evaluate the strength of the bones. … The protocol from 2009 was based on a very small cohort of patients and was at that time under scrutiny. This prompted the authors to set very vigilant monitoring protocol. As clinical experience expanded and more data became available the protocol was revised and finally published in November 2017. In that zeitgeist, the daily clinical practice had already adapted prior to the publication. However, the physical examination and the bone density monitoring remained requirements for good clinical practice (Dr P, PP, QQ and RR (2015) Arterial Hypertension as a Complication of Triptorelin Treatment in Adolescents with Gender Dysphoria. Endocrinol Metab Int J 2(1): 00008. DOI: 10.15406/emij.2015.02.00008).*

Prior to start history and physical examination to evaluate height, weight, sitting height, blood pressure, Tanner stage and overall health assessment. Additional investigations include laboratory: LH, FSH (hormones secreted by the pituitary gland that stimulate the gonads to produce sex hormones (testosteron (T) or estradiol (E2)), and 25OH vitamin D. Also bone density using DXA should be determined to evaluate the strength of the bones. …'

531. In fact the Endocrine Society Guidelines 2009 do not make recommendations for pre-GnRHa bone health assessment by DXA or any other means. They state:

'We suggest that bone mineral density measurements be obtained if risk factors for osteoporosis exist specifically in those who stop hormone therapy after gonadectomy.'

532. Likewise, WPATHSOC7 makes no reference to bone health in pre-GnRHa assessment. It states:

'During pubertal suppression, an adolescent's physical development should be carefully monitored … so that any necessary interventions can occur … to improve iatrogenic low bone mineral density…'

533. It is, by definition, not possible to detect iatrogenic changes pre-treatment. WPATHSOC7 and the Endocrine Society Guidelines 2009 are therefore recommending bone health monitoring during GnRHa therapy. This position is followed by other guidelines:

'Guidance for GPs, other clinicians and health professionals on the care of gender variant people;

RCPsych guidelines 2018;

IPPF IMAP Statement

NHS Spec E13 (HSS)/e (ill effects on bone health is a "stopping criterion" in hormone therapy);

UCSF Guidelines: "There is insufficient evidence to guide recommendations for bone testing in transgender women or men";

NHSE Commissioning Policy.'

534. Dr Y, appears to recommend bone density assessment at the start of puberty suppression. Thus, in his 2014 paper, in respect of the monitoring of pubertal suppression, Dr Y states "Bone density: DEXA T 0 and yearly". Dr Y does not explain what he meant by "T 0", but the Tribunal infers that it means time zero, ie., at the start of treatment. Dr Y does not state why he recommended a "T 0" DXA scan when this was not recommended in Endocrine

Society Guidelines 2009. The Tribunal notes, moreover, that Dr Y's paper was a single author article concerning two young transgender persons (one MTF who received puberty suppression and one FTM who received testosterone). As such, Dr Y's article lacks the authoritative status of Endocrine Society Guidelines 2009 and WPATHSOC7, which are multi-author consensus guidelines.

535. In her witness statement, Dr Webberley stated as follows:

'Patient C had a telephone consultation on 9 November 2016 and a clinic consultation on 8 December 2016 [page 24/C4c]. Patient C had a normal physical appearance and height for his age. In terms of his bone health, his medical history had elicited no concerns, and his physiological and anatomical appearance were entirely normal. Apart from height and weight, there were no further examinations required.'

536. There was therefore nothing to suggest to Dr Webberley "risk factors for osteoporosis". Patient C presented as a healthy 10/11 year old. The Tribunal finds, in the absence of evidence to the contrary, that it was reasonable for Dr Webberley to assess Patient C on the basis of his medical history and appearance at the consultation and to conclude that there were no skeletal contraindications to GnRHa therapy.

537. The Tribunal therefore finds that Dr Webberley was not under an obligation to arrange for Patient C to be examined in relation to his bone health prior to prescribing GnRHa treatment. It therefore finds paragraph 5(a)(i)1 of the Allegation not proved.

Paragraph 5

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

a. did not arrange for Patient C to be **adequately** examined prior to prescribing ~~testosterone and GnHRA~~ GnRHa treatment, including:
Amended under Rule 17(6)

i. a physical examination to determine:

2. height
3. weight

538. The Tribunal considered paragraphs 5(a)(i)(2) and (3) together.

539. In paragraph 6b of his report of 18 December 2019, Dr S states:

'NHS England's "Service Specification 1719: Gender Identity Services for Adults (Non-Surgical Interventions)" states, "Physical examination, other than the measurement of height, weight and blood pressure, must not be performed routinely during the

assessment process. Examination of genitalia and chest is not a routine part of the assessment process. Physical examination may be recommended by the clinical team only if the individual's clinical history suggests that physical examination is likely to result in important benefit to the individual, or is likely to reduce an important risk of harm; or as a response to a specific request by the individual. For this reason, it may have been inappropriate for Dr Webberley to have personally examined Patient C as part of their assessment but, as the psychosocial assessment was completed by Dr V, and Dr HW's role was restricted to endocrine management, it was necessary for her either to personally perform an examination or arrange for an examination by another medical practitioner.'

and

'Important omissions from her record of the assessment include height, weight, blood pressure and the Tanner staging of Patient C's pubertal development, specifically the stage of their pubic hair growth and breast development. These data are essential for deciding on the appropriateness of prescribing a GnRHa and testosterone.'

WPATHSOC7 states:

'All assessments should include a thorough physical exam, including weight, height, and blood pressure." This recommendation relates to initial evaluation, not pre-GnRHa work up. The purpose of this initial evaluation is "…to assesses a patient's clinical goals and risk factors for hormone-related adverse events.'

WPATHSOC7 also states under the heading 'Risk Assessment and Modification for Initiating Hormone Therapy':

'All assessments should include a thorough physical exam, including weight, height, and blood pressure.'

And:

'Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of masculinizing hormone therapy outlined in Table ", as well as individual patient risk factors, including family history'

540. The Tribunal notes that in the undated Young Person's Questionnaire (YPQ), Patient C's height and weight are recorded as *"145cm"* and *"39 kilos".* The Tribunal has determined that those height and weight measurements were obtained on or shortly before 7 November 2016, as this was the date that Patient C's mother returned the completed YPQ to Gender GP. Dr Webberley prescribed GnRHa to Patient C on 29 April 2017, some 173 days after 7 November 2016. The Tribunal has found in respect of Patients A and B that height and weight are important baseline measurements during induction of FTM trans-puberty, because serial

before and after measurements may be helpful in documenting height and weight gain as markers of response to testosterone therapy. Patient C's care plan was puberty suppression using GnRHa, not puberty induction using testosterone, and height and weight gain would not be expected in response to the GnRHa regimen.

541. Nevertheless, the Tribunal determined that height and weight measurements must, if they are to have any relevance as indicators of a patient's and fitness for GnRHa therapy, be contemporaneous with the beginning of therapy. 173 days between the obtaining of height and weight measurements and the start of puberty suppression cannot be regarded as contemporaneous by any stretch of the imagination. Dr Webberley should have obtained or arranged to have obtained fresh readings of Patient C's height and weight just prior to the commencement of GnRHa therapy and not to have done so amounts to a failing.

542. It therefore found paragraphs 5(a)(i)(2) and (3) of the Allegation proved.

Paragraph 5

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

a. did not arrange for Patient C to be **adequately** examined prior to prescribing ~~testosterone and GnHRA~~ **GnRHa** treatment, including: **Amended under Rule 17(6)**

i a physical examination to determine:

4. blood pressure

543. The Tribunal had regard to paragraph 6b of Dr S's report, as set out above.

544. It had regard to the Endocrine Society Guidelines 2009 which state:

'height and weight should be measured every three months as part of the GnRHa follow-up protocol.'

545. These guidelines, which were operative at the time Dr Webberley treated Patient C, do not stipulate that height, weight and blood pressure should be measured pre-treatment and makes no mention of blood pressure either before or after therapy. The requirement to take blood pressure was added when the guidelines were revised in 2017.

546. The Tribunal noted that Patient C's blood pressure was obtained on 17 March 2017 and this was reported to Gender GP by Patient C's mother on the same day. Dr Webberley prescribed GnRHa to Patient C on 29 April 2017, some 43 days after the blood pressure reading was taken. Patient C was, in Dr Webberley's opinion, a fit and healthy 10/11 year old.

547. Based on the evidence before it, the Tribunal determined that Dr Webberley did not fail to adequately examine Patient C prior to prescribing treatment, including a physical examination to determine Patient C's blood pressure, or fail to arrange for this to be done. It therefore found paragraph 5(a)(i)(4) of the Allegation not proved.

Paragraph 5

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

a. did not arrange for Patient C to be **adequately** examined prior to prescribing ~~testosterone and GnHRA~~ GnRHa treatment, including:
Amended under Rule 17(6)

i a physical examination to determine:

5. Tanner staging of Patient C's pubertal development, including stages of:

   i. pubic hair growth
   ii. breast development

548. The Tribunal accepted that puberty blockers should not be administered until puberty had started. This was Professor F's evidence. He observed that:

'This is a requirement set out by the international guidelines and also NHS service specification in order to allow personal experience of the effect of natural sex hormones.'

549. NHS Service specification E13/S(HSS)/e, to which he referred, stipulates that puberty suppression must await such time "when the client is in established puberty (not before Tanner Stage 2)"

550. The Tribunal therefore accepted that Dr Webberley was under an obligation to determine that Patient C had reached Tanner stage 2.

551. Table 6 of the 2009 Endocrine Society Guidelines provides information as to Tanner stages 1, 2 and 3 as regards breast development as follows:

'1 Pre-adolescent;
2 Breast and papilla elevated as small mound; areolar diameter increased;
3 Breast and areola enlarged, no contour separation.'

552. Further, the Guidelines for Primary and Gender Affirming Care of Transgender and Nonbinary People published on 17 June 2016 includes Appendix 4:

'Definition of Tanner Stages

Adolescents experience several types of maturation, including cognitive (the development of formal operational thought), psychosocial (the stages of adolescence), and biologic. The complex series of biologic transitions are known as puberty, and these changes may impact psychosocial factors. The most visible changes during puberty are growth in stature and development of secondary sexual characteristics. Equally profound are changes in body composition; the achievement of fertility; and changes in most body systems, such as the neuroendocrine axis, bone size, and mineralization; and the cardiovascular system. As an example, normal cardiovascular changes, including greater aerobic power reserve, electrocardiographic changes, and blood pressure changes, occur during puberty.

The normal sequence of pubertal events and perils of puberty are reviewed here. This is within the normal ranges and does not take into account Precocious Puberty or Delayed Puberty.'

See http://www.childgrowthfoundation.org/CMS/FILES/Puberty_and_the_Tanner_Stages.pdf See http://www.rcpch.ac.uk/child-health/research-projects/uk-who-growth-charts/ukgrowth-chart-resources-2-18-years/school-age#cpcm for a simpler classification and explanation of puberty development.

553. The Royal College of Paediatrics and Child Health publication includes the following:
Pubertal Assessment
The puberty 'phase' may be ascertained through simple questions about the appearance of secondary sexual characteristics as well as by clinical examination.
By history from parents, carers or young person

Pre-puberty	*In Puberty*	*Completing Puberty*
(Tanner stage 1)	*(Tanner stages 2-3)*	*(Tanner stages 4-5)*
No signs of pubertal development	*Any breast enlargement pubic or armpit hair*	*Started periods with signs of pubertal development*

554. Dr Webberley did not examine Patient C. She relied on the answers which Patient C gave in the YPQ which included the following observations:

I would like to not have boobs;

I'd like my boobs cut off - they wobble now and get on my nerves;

I want to have hormone blockers to stop my boobs growing because they are getting too big now. I know the boobs won't go away;

I wont have to cover up my boobs as they get bigger and so will still be able to pass as a boy to people who don't know;

I dont like the idea of injections I'm terrified so I hope I can go through with them. If I can't I think I'd rather be dead than grow bigger boobs.

What changes are you most looking forward to…? My boobs stopping growing.

555. The questionnaire is not dated but, as mentioned, it was returned by Patient C's mother to Gender GP on 7 November 2016. Moreover, Dr V saw Patient C and his mother in consultation on 8 December 2016 and 21 January 2017.

556. She also relied on communications with Patient C's mother as follows:

17/10/16	*I have a 10 year old ftm has been living as a boy since the end of May when he 'came out'. Going through puberty pretty early, is in between Tanner stage 1 and 2. Breasts began growing at age 9.*
9/11/16	*Puberty has started and there is some small breast growth.*
27/2/17	*I have amended a couple of things on the letter to the GP, notably the times frames, and also that the fact Patient C has just started his periods (today) regrettably.*
19/4/17	*Please do let me know that payment has been received and when we can proceed. Patient C is getting quite distressed this end at the wait and last night began to talk of not wanting to live as well as re-iterating how much he detests his body. Its imperative he starts the blockers at the earliest opportunity. I cant wait for the GP to respond/come round, we can deal with them later. Its now over 3 months since we requested to start the blockers and body is literally changing by the day, he has had 2 periods and his breasts are expanding rapidly. Hips are also changing shape now. Please can we work hard to get this all in motion for his sake Thank you*

557. In respect of breast development, the Tribunal did not consider that Dr Webberley was obliged to examine Patient C or arrange for Patient C to be examined by anyone else in the light of the information which she had from Patient C and his mother. It noted that according to the Royal College of Paediatrics and Child Health publication the relevant information can be obtained from parents, carers or young person. It found that she had sufficient information to determine that, in respect of breast development, Patient C had reached at least Tanner stage 2 which met the requirement of the NHS Service specification E13/S(HSS)/e to which Professor F referred.

558. The Tribunal recognised that Dr Webberley obtained no information from Patient C or his mother concerning Patient C's pubic hair growth. It regarded the Royal College of Paediatrics and Child Health publication as ambivalent as to whether pubic hair growth was a necessary finding to conclude that an adolescent was in Tanner stage 2-3. It read: 'Any breast

enlargement pubic or armpit hair'. The GMC did not present to the Tribunal any other document setting out what physical developments need to be present to identify Tanner staging 2-3. In any event, it found that ascertaining pubic hair growth was not necessary to determine whether Patient C had attained at least Tanner Stage 2 in the context of Dr Webberley being informed by Patient C's mother that he had started periods and his hips were expanding rapidly. The Tribunal did not therefore consider that Dr Webberley was obliged to examine Patient C or arrange for Patient C to be examined by anyone else to ascertain pubic hair growth in the light of the information.

559. In the light of the foregoing, the Tribunal found paragraph 5(a)(i)(5) of the Allegation not proved.

Paragraph 5

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

a. did not arrange for Patient C to be **adequately** examined prior to prescribing ~~testosterone and GnHRA~~ **GnRHa** treatment, including:
Amended under Rule 17(6)

ii. full psychological pre-diagnostic input to:

1. clarify diagnoses;
2. explore additional factors, including Attention Deficit Hyperactivity Disorder;

560. This paragraph of the Allegation appears to stem from Dr Q's observation in his report as follows:

'[Patient C] had received a diagnostic assessment from Dr. V (counselling psychologist) prior to being accepted to Gender GP services. There was no psychology input from Dr V following the initial assessment.

The psychology input did not fully explore differential/co-morbid diagnoses (e.g. ADHD) indicated by Patient C's mother's developmental history and background in in-utero exposure to heroine. Screening measures or multi disciplinary assessment should have been used to ascertain the need for further investigation. No referral was made to explore a diagnosis of ADHD.

This is of concern because this may have impacted on formulation, treatment and ongoing management.

• There was a failure to provide the full psychological pre-diagnostic input recommended by WPATH and the NHS service specifications around clarifying diagnoses.
• The assessment provided by Dr V was thorough and informed well by her expertise in gender dysphoria, however as an initial psychological assessment it lacked breadth and did not fully explore additional factors such as ADHD.'

561. In evidence Dr Q said:

'The WPATH guidelines are really clear. That is a core function of a mental health professional in the diagnostic process. We should be looking out for other possible alternative diagnoses that may provide an alternative explanation for the dysphoric feelings or complicate them, and we should be resolving those issues before we make a diagnosis of gender dysphoria or proceed with gender confirming approaches. That is not because a diagnosis of autism or ADHD precludes a diagnosis of gender dysphoria, but these unmanaged issues, unidentified and unmanaged issues, can create problems in the process of transition and adjustment to the process and the diagnosis of gender dysphoria. Starting off from a position of having a good, solid formulation and understanding of the young person is the best, most protective way to proceed with a long-term treatment that requires ongoing support.'

And later:

'MR JACKSON: ... what I just want to understand is, in terms of using that as the touchstone for WPATH, how is the psychologist to look at the issue of ensuring that the youth, the individual who comes for review, is understanding of the processes that may be involved in order for them then to be involved in the consenting or agreeing to different sorts of treatment – and we will come back to the issue of the age at which that takes place.
A It wouldn't be the sole responsibility of the psychologist to do it. These judgements are made by the intervening clinician, but psychologists would have valuable information to add to that intervening clinician's judgement of whether a patient, a child, an adolescent had the capacity or the competence to consent. The key way that we might contribute is if there are other diagnoses like ADHD, a possible learning difficulty, that might impact on information processing, but also a really good assessment of the dysphoria itself, because dysphoria is characterised by distress. This is a condition when children are sufficiently distressed, their reasoning is impacted, so far as to cause them to try and injure themselves by cutting off their genitals, scratching off their breasts. It does impact. An assessment of that core symptom, the dysphoria, needs to be detailed, and if it is present, it needs to be established whether the distress would inform decision making, because it may be that reducing the stress from that dysphoria, which is the same thing, would lead to different choices to be made in treatment.'

And still later:

'Only in that you would want that information before assessing capacity or competence for consent. You would want to know what - there are a lot of risk indicators for neural difference for this patient. There was an auditory processing disorder which can affect information processing and reasoning; there was a specific learning disability - I think it was dyslexia; there was a question of ADHD and that affects the intake of information and the impulsivity of decision-making. All of these things point towards the stronger possibility of ASD, which again has big implications for whether a person can make their own decisions and can be flexible, etc, as laid out. So I think these are important questions to resolve before continuing with a gender dysphoria assessment or should have been done at the same time, and that is what WPATH recommends, is that these issues are resolved before treatment because they can massively complicate treatment.'

562. Dr Q is therefore making the following assertions:

- Patient C should have been screened for:
  - other possible alternative diagnoses that may provide an alternative explanation for the dysphoric feelings or complicate them;
  - other coexisting mental health issues in order for these to be optimally managed prior to, or concurrent with treatment for gender dysphoria.
- Patient C should be assessed for capacity or competence for consent in the context of:
  - his auditory processing disorder which can affect information processing and reasoning;
  - his specific learning disability – dyslexia;
  - ADHD which affects the intake of information and the impulsivity of decision making.

563. In respect of the latter aspect, Dr T stated:

'Yes, so I think we would agree that we would never consider not treating somebody because they have any kind of co morbid condition, but with something like ADHD, which obviously affects ability to focus and concentrate and process information, what we would be considering is what is the best format that we need to provide that information to the young person, how can we enhance their competence in terms of their grasp of that information, and just being very mindful that we are bringing a lot of thought to ensuring that the young person does have a good grasp of the information before we proceed.'

564. Dr V set out her position in her witness statement:

'It is my opinion that this family engaged with me as it pertained to my specialist input to the extent that a diagnosis of gender dysphoria and recommendation for treatment could be made. Further engagement with healthcare specialists cannot and should not

be coerced or forced. This is true of the NHS, private healthcare and healthcare around the world. Whether or not to engage in any healthcare process constitutes personal freedom and patient's wishes must be respected.'

565. In respect of this statement, Dr Q stated in a further report:

'16 … Whilst contact with healthcare specialists should not be 'forced or coerced', it cannot be avoided or denied if the patient is seeking a clinical intervention and has clinical need. I am unsure as to what this statement is in reference to. There was no issue of coercion into counselling sessions simply because Patient C had requested them via Dr V's assessment; however she did not go on to make a recommendation for these. And the conditions under which Dr V should be proactively involved in Patient C's care within this opt-in model were not outlined in the report or any other paperwork provided to me.

This is not correct as ADHD was not explored. WPATH guidance clearly states that comorbidities should be explored in the process of gender dysphoria diagnosis and subsequent treatment:

> *"The role of mental health professionals includes making reasonably sure that the gender dysphoria is not secondary to, or better accounted for, by other diagnoses."*
>
> *"Mental health professionals should screen for these [co-morbidities] and other mental health concerns and incorporate the identified concerns into the overall treatment plan. These concerns can be significant sources of distress and, if left untreated, can complicate the process of gender identity exploration and resolution of gender dysphoria (Bockting et al., 2006; Fraser, 2009a; Lev, 2009).*
>
> *Addressing these concerns can greatly facilitate the resolution of gender dysphoria, possible changes in gender role, the making of informed decisions about medical interventions, and improvements in quality of life."*

Where there were other indicators of neurodifference (specific learning difficulty, auditory processing disorder), and an articulated concern about ADHD, and a specific risk factor/diathesis (inutero opioid exposure) it is the role of the psychologist (mental health professional) to undertake an ADHD assessment.

17 Dr V may be fully aware of the processes involved in diagnostics. However I do not questions her knowledge, I assert merely that the diagnostic process for ADHD was not followed. There was no ADHD assessment reported in her report, simply a description of Patient C's behaviour which is not sufficient to base a conclusion on, in light of the aforementioned associated risk factors. WPATH instructs these things should be explored (please see reference in point 16). For Patient C this is of direct relevance as if

he were to meet criteria, then this may require treatment with stimulants. During the titration phase it is not uncommon or children and adults to experience anxiety, agitation, insomnia and psychiatric disturbance whilst the body adjusts to the medication. This is not a process that one would want to commence simultaneously with puberty blockers or hormone treatment.

If Dr V recommended that the parents may wish to pursue a diagnosis of ADHD privately, this implies that despite her observational based conclusions, that she believed that there was a possibility that Patient C met criteria or that her own assessment was possibly wrong/insufficient. If this is the case, and she did not offer the ADHD assessment, it is difficult to see how she can also claim that the psychological assessment did not lack breadth.

18 This is not sufficient to disqualify ADHD as a possibility, especially with a known developmental diathesis and no other explanation for the ADHD-type presentation.'

566. Although Dr V stated in her report:

IMPRESSION

Patient C presented as stable with no contributory psychiatric history and gave a good account of himself.

RECOMMENDATION

3 … Patient C did not present with any disqualifying medical or psychiatric condition.'

she acknowledges that she did not make a formal assessment of ADHD. She said in evidence:

'I included these details in my report because I thought when we considered whether or not they were relevant to the ability to consent, and I gave my opinion. I also suggested to the family that they may wish to pursue further support with respect to these issues on an ongoing basis. That is wholly up to the family whether or not they pursue further diagnoses, further assessment. It is not contraindicative to passing the individual on for treatment. There is no literature anywhere that suggests if an individual can consent, and they meet the criteria for a diagnosis of gender dysphoria that they should not be started on treatment.'

And later:

'If I may explain something. I think there's a nuance issue here that we need to appreciate before we go forward with respect to NHS care and private health care. If someone is going to - if somebody needs a specialist assessment for ADHD or for ASD, the referral must come from the GP and the referral must be sought by the family or the patient themselves. Neither Dr Webberley nor I have the capacity to issue that referral within the NHS because the NHS don't accept it. Neither do we have the

capacity to force a patient into private, lengthy and expensive assessments before we start them on care, especially if we see that starting them on care is towards harm reduction, is going towards harm reduction and if they have the capacity to consent. So absolutely this is not a factor that needed to be assessed at length before the individual could start with treatments.'

567. So Dr V considered ADHD in relation to consent, not to screen for:

- other possible alternative diagnoses that may provide an alternative explanation for the dysphoric feelings or complicate them;
- other coexisting mental health issues in order for these to be optimally managed prior to, or concurrent with treatment for gender dysphoria;

568. The Tribunal finds that this is not consistent with the approach recommended by WPATHSOC7.

569. To be clear, this is not about whether a diagnosis of ADHD precludes diagnosis and treatment for Gender Dysphoria. All clinicians agree that it does not. For example, Dr W stated:

'There is no evidence that a diagnosis of ADHD would preclude treatment for gender dysphoria if this is required. I have a number of trans patients who receive gender affirming medical treatments, including hormones and surgery under my care with ADHD.'

570. The Tribunal accepted that Dr V, over the two sessions lasting in total some three hours, was able to satisfy herself that Patient C had the capacity and competence for consent to treatment for gender dysphoria; i.e whether he was able to concentrate on the information concerning his treatment, process it and grasp it before proceeding. She stated in her report:

'PSYCHIATRIC HISTORY
[Patient C] *has been diagnosed with dyslexia and reportedly struggles with auditory processing. mother also suggested some concern about potential attention deficit/hyperactivity disorder (ADHD), though no formal diagnosis has been needed. Across the course of three hours of discussion/assessment with me,* [Patient C*] was polite, attentive and patient. He was engaged throughout, took turns speaking with others present, and showed a reasonable degree of concentration. From this perspective, a diagnosis of ADHD does not seem pressing, though his parents may wish to pursue ADHD-specific assessment.*

571. However, Dr V did not address herself to the other matters recommended by WPATHSOC7 namely:

- other possible alternative diagnoses that may provide an alternative explanation for the dysphoric feelings or complicate them;
- other coexisting mental health issues in order for these to be optimally managed prior to, or concurrent with treatment for gender dysphoria;

572. Dr V had great experience in diagnosing and recommending treatment for gender dysphoria. The question therefore arises why she did not address herself to these other matters. Dr Q suggested that she might not be competent to do so as she was a counselling psychologist. The Tribunal makes no finding in that regard – she described herself as a Chartered Psychologist and Gender Specialist. Dr Webberley did not record the instructions which she gave to Dr V when she arranged for Patient C to consult with her. Dr V's evidence as to her instructions was simply, as mentioned:

> *It is my opinion that this family engaged with me as it pertained to my specialist input to the extent that a diagnosis of gender dysphoria and recommendation for treatment could be made.*

573. On the evidence before it, the Tribunal concluded that Dr Webberley did not request Dr V to address these matters. Pursuant to the recommendations of WPATHSOC7, it found that she ought to have done. The Tribunal therefore found paragraph 5(a)(ii)(1) and 5(a)(ii)(2) proved.

Paragraph 5

> 5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:
>
> > b. did not record the details of any assessment as set out at paragraph 5a above;

574. In view of its findings in respect of paragraphs 5(a)(i)1 and 5(a)(ii), the Tribunal considered only paragraphs 5(a)(i)(2), (3), (4) and (5).

575. The Tribunal finds that Dr Webberley did make a sufficient record of Patient C's height, weight and blood pressure. It therefore determined that paragraph 5(b) in relation to paragraphs 5(a)(i) (2), (3) and (4) were not proved.

576. Dr Webberley did not record her findings in respect of Tanner stage. She retained emails that contained observations that underpin Tanner staging, but she did not record her conclusion as to what those observations indicated as to Patient C's Tanner stage at presentation or at the juncture of prescribing GnRHa. The Tribunal therefore find that Dr Webberley did not record details of her assessment in that regard. It was not sufficient for her to retain emails that collectively formed the basis of her decision as to Tanner staging: continuity of care required that any other clinician would readily be able to ascertain what Dr

Webberley had decided as to Patient C's Tanner stage at presentation and when she prescribed GnRHa. Not to have done so was a failing.

577. It therefore found paragraph 5(b) proved insofar as it related to paragraph 5(a)(i)(5).

Paragraph 5

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

c. prescribed ~~GnRHa~~ GnRHa to Patient C without **(Amended under Rule 17(6))**

i. the adequate training, qualifications or experience in the field of paediatric endocrinology;
ii. working as part of a specialist multidisciplinary team in gender care for children and adolescents;

578. The Tribunal considered paragraphs 5(c)(i) and (ii) together.

579. The Tribunal has already set out, at the outset, its consideration of Dr Webberley's training, qualifications or experience in the field of paediatric endocrinology, and it has explained its reasons for finding that she was, at the material time, a GP with a special interest in gender dysphoria and was competent in the roles of mental health professional and hormone prescriber. The Tribunal's detailed reasons for finding such are set out in paragraphs 117 – 204 above. As part of its consideration of this question, the Tribunal considered, based on the evidence adduced during the proceedings, that Dr Webberley adopted a hub-and-spoke approach to her care for Patients A, B and C, referring them to specialists if and when required. The Tribunal also determined that Dr Webberley was competent to determine when such referrals were necessary. Further, the Tribunal considered that Dr Webberley was not, at the time, bound to follow precisely WPATHSOC7 or the Endocrine Society Guidelines 2009, although she did avail herself of the guidance therein. She was at liberty as an autonomous medical practitioner to look to alternative guidance and did so. Her reliance on the UCSF Guidelines was in accordance with a responsible body of expert medical opinion.

580. The Tribunal also adopted its reasoning and findings, set out in this determination in relation to paragraph 1(l)(i) which makes a similar allegation in relation to Patient A in respect of the period before the inception of treatment by Dr Webberley, namely before she prescribed testosterone, though in the case of Patient C, it is GnRHa.

581. Given the Tribunal's finding that Dr Webberley was, at the material time a GP with a special interest in gender dysphoria and she was competent in the roles of mental health professional and hormone prescriber, the Tribunal was satisfied that she had the adequate

training, qualifications or experience in the field of paediatric endocrinology. It therefore found paragraph 5(c)(i) of the Allegation not proved.

Paragraph 5

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

d. Advised Patient C as to the risks of ~~GnRHA~~ GnRHa before commencing treatment without; **Amended under Rule 17(6)**

i. the adequate training, qualifications or experience in the field of paediatric endocrinology;
ii. working as part of a specialist multidisciplinary team in gender care for children and adolescents;

582. The Tribunal has considered paragraphs 5(d)(i) and (ii) together.

583. The Tribunal has already found paragraphs 5(c)(i) and (ii) of the Allegation not proved. It also relies upon its finding and reasoning in respect of paragraphs 1(l)(i) and 6(b). It follows, therefore, that these paragraphs of the Allegation are not proved.

Paragraph 5

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

d. Advised Patient C as to the risks of ~~GnRHA~~ GnRHa before commencing treatment without; **Amended under Rule 17(6)**

iii. discussing the risks to Patient C's fertility;

584. The Tribunal was mindful that, according to WPATHSOC7, gender dysphoria is to be managed in stages. Stage 1 is suppression of puberty, using, for example, GnRHa; stage 2 is the induction of trans-puberty by administration of GAH (testosterone in the case of FTM transition). Stage 1 interventions are regarded as reversible, whereas the reversibility of stage 2 interventions is less certain and in some cases may be irreversible. The Tribunal also bore in mind Professor F's evidence that approximately 95% of persons accepting stage 1 interventions go on to request stage 2 treatment.

585. The Tribunal had regard to the Informed Consent form which was completed on 9 February 2017. The Tribunal noted that the consent form refers to both 'puberty blockers' and 'testosterone'. However, the only mention in respect of fertility risks is in the context of testosterone treatment. This reads:

'This will probably mean that I will not menstruate (have "periods"), and that I will not be fertile (able to get pregnant) for the duration of the treatment.'

586. The Tribunal was of the view that whilst form does touch upon fertility, it does not spell out, in any detail, the seriousness of or the profound impact of the treatment in relation to fertility. In particular, it does not explain that the likelihood is that a patient who commences treatment with GnRHa will go on to receive GAH treatment and that therefore, embarking on GnRHa treatment is likely to have a profound effect on his fertility.

587. The Tribunal also had regard to email correspondence between Dr Webberley's clinic and Patient C's mother on 26 February 2017. These state as follows:

Email of 26 February 2017 (timed at 4:12 pm)
'Hi [Patient C's mother] apologies for the delay. One of the things we haven't discussed is fertility, is this something you have discussed and have full knowledge of or is this something we need to explore a bit further? Dr Webberley'

Email of 26 February 2017 (timed at 4:31 pm)
'Hi Helen
It is something we have discussed with he is adamant he doesnt want children but I'm not sure thats something an 11 yr old can be definite about?
Blockers, though, as we understood, are not supposed to interfere with fertility are they?'

Email of 26 February 2017 (timed at 5:06 pm)
'Sorry Helen, re my reply below..just be clear, obviously we understand fertility is affected whilst taking the blockers..but it is our understanding that fertiltity [sic] would return if blockers are stopped..is that correct? At that point, he would have to experience a return to a female puberty should he decided he wants eggs harvested and stored? We are aware that harvesting eggs is not an easy process and storage costs would be incurred. Is there any other information we might need?'

588. Whilst the Tribunal accepts this demonstrates that some discussion did take place between Dr Webberley and Patient C's mother, it is not satisfied that this is sufficient in relation to the risks and consequences upon fertility of what is life changing treatment. Further, the Tribunal has not been provided with any contemporaneous notes or objective evidence to be satisfied Dr Webberley discussed the risks to Patient C's fertility.

589. The Tribunal therefore found paragraph 5(d)(iii) of the Allegation proved.

Paragraph 5

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

e. did not assess Patient C's capacity to consent to treatment;

590. The Tribunal refers to its determination at paragraph 3(f) in relation to Patient B. Save insofar as the reasoning therein relates exclusively to Patient B, it relies on that reasoning in relation to paragraph 5(e). The Tribunal noted that Dr V addressed the issue of whether Patient C was able to concentrate on the information concerning his treatment, process it and grasp it before proceeding. Further it noted her impression and recommendation. In the circumstances, the Tribunal found paragraph 5(e) of the Allegation not proved.

Paragraph 5

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

f. in the alternative to paragraph 5e, did not record any assessment of Patient C's capacity to consent;

and

g. did not record Patient C's reasoning ability and competence with regards to his treatment;

591. The Tribunal considered paragraphs 5(f) and 5(g) together.

592. The Tribunal noted that Dr Webberley did not record her own assessment of Patient C's capacity to consent, nor his reasoning ability and competence in regard to his treatment. The treatment which Dr V recommended he should undergo was serious. As mentioned, Professor F's evidence was to the effect that the vast majority of adolescents who receive GnRHa treatment, go on to take GAH. This is a profound change in a young person's life and will affect fertility.

593. The Tribunal noted that these paragraphs closely reflect paragraphs 1(f) and 3(g) of the Allegation which relate to Patients A and B respectively. The Tribunal found those paragraphs proved. In considering paragraphs 5(f) and 5(g) of the Allegation, it also had regard to the reasoning which informed those determinations.

594. The Tribunal considers that Dr Webberley did have an obligation to record these matters. It therefore found paragraphs 5(f) and (g) proved.

Paragraph 5

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

h. did not provided adequate follow-up care to Patient C after initiating ~~GnRHA~~ GnRHa treatment in that you:
Amended under Rule 17(6)

i. failed to monitor Patient C's physical development;
ii. did not review Patient C's treatment plan with a multidisciplinary team when Patient C started his menstruation cycle, including considering the prescribing of progestins;

595. The Tribunal has considered these two paragraphs together.

596. The Tribunal noted that Dr Webberley ceased to practise shortly after 9 May 2017, the date upon which she had conditions imposed by an Interim Orders Tribunal. In her statement of 9 August 2021, Dr Webberley states:

> *'My first prescription to Patient C was on April 30 2017, [page 96/C4c]. I did not work after the date of 10 May 2017 due to restrictions imposed on my medical registration, and thus did not have the opportunity to follow up Patient C myself to monitor his physical development.'*

597. The Tribunal noted, in the letter of 23 June 2017 from Dr Webberley's solicitors to the ABUHB, that one of the conditions imposed on her clinical practice requires that her transgender work shall be supervised by a clinical supervisor, and that clinical supervisor must be approved by our Client's responsible officer.

598. The Tribunal noted that Dr Webberley's conditions required her supervisor to be approved by her responsible officer, which in this case was Dr OO, also Medical Director at ABUHB.

599. In a letter dated 31 July 2017, sent via email, to Dr N and Dr OO at the ABUHB, Dr Webberley sets out a chronology of correspondence between herself and ABUHB in relation to the nature of the concerns about her clinical practice, and her attempts to arrange for supervision of her clinical practice by Dr Z. The Tribunal noted a paragraph which states:

> *'Thank you for informing me that Dr OO has been 'dealing directly with the proposed supervision arrangements in respect of your adult transgender patients', however my query related to all of my transgender patients, not solely the adult patients. I have forwarded you a letter dated 19th May 2017 from Dr Z offering clinical supervision, having spoken to his MD, his MDT and Professor I (paediatric endocrinologist and complainant). I have not had any correspondence from Dr Z altering this offer, and I am still awaiting your approval of Dr Z as my supervisor. Please confirm the situation regarding this as a matter of urgency as I am currently unable to work as an NHS GP or in my capacity as a gender specialist.'*

600. The Tribunal took this to suggest that Dr Webberley did make an attempt to appoint Dr Z as her supervisor, which would have enabled her to continue provide care to her patients, but due to the limited areas in respect of which he could provide supervision, the Board did not approve this.

601. Dr P in his report in respect of these matters stated:

> *'The prescribing physician is responsible for the safety monitoring of the therapy. The execution of the safety monitoring is feasible in various forms. The most common clinical practice is that the prescribing physician follows-up the patient in person and does the physical examination him/herself. But also a shared-care model is used in which some monitoring tasks are done by a second party. From the documentation provided, it is not clear how the shared care was regulated and some monitoring was lacking such as blood pressure, as mentioned previously. The registration of the follow-up and thus maybe the execution did meet the level of adequate care.'*

Dr P here is stating what should have happened or would normally happen.

602. Dr S in his report in respect of these matters stated:

> *'The Standards of Care state that, "During pubertal suppression, an adolescent's physical development should be carefully monitored – preferably by a paediatric endocrinologist – so that any necessary interventions can occur (e.g., to establish an adequate gender appropriate height, to improve iatrogenic low bone mineral density)." Dr Webberley's records include copies of laboratory reports, measurements of blood pressure height and weight made by Patient [C] or their mother, and several self-reports and observations from Patient [C]'s mother regarding Patient [C]'s presumed response to treatment and their physical, psychological and social well-being.'*

603. On the basis of the evidence, therefore, the Tribunal found paragraphs 5(h)(i) and (ii) of the Allegation not proved.

Paragraph 5

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

i. did not maintain an adequate record of Patient C's care in that entries in records were:

i. infrequent;
ii. made by administrative staff;
iii. unclear as to who had made them;

iv. made using email print-offs rather than an electronic record system;

604. This paragraph of the Allegation stems from the report of Dr S in which he observed:

'Inadequate record-keeping:

The medical records kept by a reasonably competent GP are, in comparison with those kept by psychiatrists, usually in 'short note' or 'bullet point' form and omit most negative findings. However, allowing for this difference in record-keeping practice, Dr Webberley's patient records do not adequately describe Patient C's care. Entries by Dr Webberley are infrequent; some of her decisions are recorded by administrative staff, rather than personally, and it is not always evident as to who has made a record entry. The document appears to be a print-out of email correspondence and lacks important features of an Electronic Health Record.'

605. The Tribunal noted that the paragraph of the Allegation alleges a failure to maintain an adequate record of Patient C's care; the equivalent paragraph in respect of Patient A concerned his treatment. The Tribunal interpreted this paragraph as referring to the whole period when Patient C was being cared for by Dr Webberley – that is from when she was first contacted by Patient C's mother by email on 17 October 2016 to when she withdrew from caring for Patient C by virtue of the conditions imposed upon her registration.

Paragraph 5

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

i. did not maintain an adequate record of Patient C's care in that entries in records were:

i. infrequent;

606. The Tribunal understood Dr S's criticism of Dr Webberley's entries in the records being infrequent as not reflecting the care which she was committed to deliver for him. It has already made three findings in this regard, in that she did not record:

- the Tanner staging of Patient C's pubertal development;
- her assessment of Patient C's capacity to consent;
- Patient C's reasoning ability and competence with regards her treatment.

607. Further, she did not record the basis of her instructions to Dr V when referring Patient C to her for psychological assessment. The Tribunal has referred to this in its findings in relation to paragraph 5(a)(ii)1 and 2.

608. In respect of Dr V's report dated 25 January 2017, notwithstanding the huge significance of it to Patient C and his mother, Dr Webberley did not make any record that she had personally read it and reflected upon it, nor whether she was satisfied with it, nor how she considered it should inform her proposed treatment of Patient C's gender dysphoria, nor as to what the next steps should be. Indeed, it was not until 27 February 2017 that Dr Webberley made any reference to the fact that a psychologist 'had been seeing Patient C' even though Gender GP had received Dr V's report on 9 February 2017. The report was, of course, included in the electronic record in respect of Patient C.

609. The Tribunal has considered the above matters. It has determined that they support the allegation that Dr Webberley failed to provide good clinical care in that she did not maintain an adequate record of Patient C's care in that her records were infrequent. Paragraph 5(i)(i) of the Allegation is, therefore, found proved.

Paragraph 5

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

i. did not maintain an adequate record of Patient C's care in that entries were:

ii. made by administrative staff;

610. The Tribunal noted that many of the entries in the records which Dr Webberley kept in respect of Patient C were made by administrative staff. The Tribunal did not find that this in itself represented a failure on her part to provide good clinical care for Patient C. It therefore found paragraph 5(i)(ii)) not proved.

Paragraph 5

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

i. did not maintain an adequate record of Patient C's care in that entries were:

iii. unclear as to who had made them;

611. The Tribunal noted that whilst the entries in Patient C's records were attributed to individuals, the exact identity of those individuals was not always disclosed both in terms of the full name of the individual, and as to the position which he or she held at Gender GP. In particular it was not necessarily clear that the entries were made by a member of the administrative staff or by a health care professional. It might be that upon a thorough perusal of the electronic records as a whole, the identity and position of the person who made an

entry could be ascertained. However, if a clinician were perusing the record at a later date, it should not be the case that he or she would have to conduct an investigatory exercise as to who completed the entries. That should be plain from the face of the record.

612. The Tribunal therefore found that Dr Webberley failed to maintain an adequate record of Patient C's care in that it was not clear who had made entries in the record. Accordingly, the Tribunal found paragraph 5(i)(iii) of the Allegation proved.

Paragraph 5

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

i. did not maintain an adequate record of Patient C's care in that entries were:

iv. made using email print-offs rather than an electronic record system;

613. As mentioned, Dr S included the following in his observation about Dr Webberley's record:

'The document appears to be a print-out of email correspondence and lacks important features of an Electronic Health Record.'

614. Dr S was reflecting upon the record as provided to him. Paragraph 5(i)(iv) attempts to translate that reflection into an allegation. The Tribunal was concerned whether it should interpret the allegation as a criticism of Dr Webberley's practice of using email correspondence as a method of record keeping. Email correspondence is of course electronic, and does not depend on print-offs. In her witness statement, Dr Webberley stated that:

'The emails sent and received between myself and Patient A and his Mother form part of the record in the electronic medical health record system.

I apologise that the printing format of the records makes it difficult to read sometimes. However, the electronic health record system in real life is not a series of print-offs. I have included the screenshots as an example. This is exhibited as 'Exhibit 4'.'

615. The Tribunal has perused 'exhibit 4'. The screenshots did not give the Tribunal confidence that Dr Webberley was maintaining an electronic system which logged the care which she was providing for Patient C. It considered that a major component of her record was contained in the emails which she dictated, drafted and / or sent to her patients, their mothers and her staff. That reflected Dr Webberley's case.

616. However, the Tribunal determined that it should not interpret paragraph 5(i)(iv) of the Allegation as referring to entries made by Dr Webberley in the record by email, rather than through a conventional records database.

617. The Tribunal will say that it found Dr Webberley's system of recording care by email to be unsatisfactory. It did not produce a log or a narrative of the care which she was engaged to deliver to Patient C; it was therefore a 'lazy' system, one which depended on the time when Dr Webberley chose to draft or send an email. It was not direct, nor timely. It was passive in that it generated record keeping when there was a need to communicate with patient, parent, or staff. Whether or not the emails had to be printed off were in the view of the Tribunal not relevant to whether the record was adequate. The Tribunal therefore found paragraph 5(i)(iv) of the Allegation not proved.

Paragraph 5

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

j. did not engage in and/or with an adequately trained and specialist multidisciplinary and interdisciplinary team, in that you did not seek:

i. any input before and during treatment from a paediatric endocrinologist;

618. This allegation is similar to that alleged at paragraphs 1(l)(i) in relation to Patient A and 3(j)(i) in relation to Patient B respectively.

619. The Tribunal adopted its reasoning and findings, as set out in respect of those allegations. In summary, although Dr Webberley had access to a multidisciplinary team, that team did not include a paediatric endocrinologist. Dr Webberley did not therefore seek input before and during treatment of Patient C from a paediatric endocrinologist. The issue for the Tribunal to determine was whether she had an obligation to do so. To answer this question, the Tribunal took account, as mentioned at paragraphs 1(l)(i) and 3(j)(i), of:

The Endocrine Society Guidelines 2009 – which does not stipulate that hormones need to be given by a paediatric endocrinologist

The Endocrine Society Guideline 2017 version – which refers only the 'clinician'

The WPATHSOC7 – which refers to the 'hormone prescriber'

Dr Y's publication Approach to the Patient: Transgender Youth: Endocrine Considerations dated December 2014 – which did not stipulate that hormone treatment must be given by a paediatric endocrinologist

The Guidelines for Primary and Gender Affirming Care of Transgender and Nonbinary People – upon which Dr Webberley relied – which states *'Providers of transgender youth care should be skilled at meeting the needs of young people presenting for care at any stage in their process. The care of transgender youth does not need to be limited to pediatric endocrinologists. General pediatricians, specialists in adolescent medicine, family medicine, medicine/pediatrics, as well as nurse practitioners, physician assistants and others are all potentially qualified to provide high quality care for transgender youth.'*

620. The Tribunal also had regard to the evidence of Dr U, as set out in the relevant paragraphs under 1(l)(i) and 3(j)(i) above.

621. Having already determined that Dr Webberley was qualified and trained and had the competency to treat patients with gender dysphoria, the Tribunal concluded that Dr Webberley did not have a duty to seek input before and during treatment from a paediatric endocrinologist, as it has already accepted that she had the competence to prescribe hormones.

622. The Tribunal therefore found paragraph 5(j)(i) of the Allegation not proved.

Paragraph 5

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

j. did not engage in and/or with an adequately trained and specialist multidisciplinary and interdisciplinary team, in that you did not seek:

ii. psychological input following an initial assessment;

623. The Tribunal was mindful that paragraph 5(j)(ii) of the Allegation, which relates to Patient C, is expressed in similar terms to paragraph 1(l)(ii) and paragraph 3(j)(ii) of the Allegation, which relate to Patients A and B respectively. The patients are different, but the principles which the Tribunal considered and upon which it relied in order to reach its determination are the same. Insofar as the reasoning in its determination in respect of paragraphs 1(l)(ii) and paragraphs 3(j)(ii) of the Allegation is not exclusive to Patients A and B, the Tribunal relies upon it in relation to paragraphs 5(j)(ii).

624. Further the Tribunal relies upon its determination at paragraph 4(b) above.

625. The Tribunal therefore finds paragraphs 3(j)(ii) not proved.

Paragraph 5

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

j. did not engage in and/or with an adequately trained and specialist multidisciplinary and interdisciplinary team, in that you did not seek:

iii. input from services already engaged in Patient C's care at the Tavistock;

626. The Tribunal noted the chronology relating to Patient C leading up to the first consultation with Dr Webberley.

627. On 6 July 2016, Dr WW, Patient C's GP, wrote to the Tavistock and Portman NHS Foundation Trust stating:

'This child was brought to me by her mother as [Patient C] has expressed feelings that she may not be biologically female, but feels and behaves in a more male gender role. [Patient C] is quite clear about the feelings she has at the present time. There appeared to be no issues with developmental milestones historically. I understand that [Patient C] is home schooled, but does have interaction with other children socially. This is obviously a distressing situation for [Patient C] and I would be very grateful for your assistance. I have given [Patient C's] mother your details to contact your clinic also and I look forward to hearing from you.'

628. The Tribunal noted a letter, to which was attached a referral form dated 16 August 2016, GIDS advised:

'Young people referred to GIDS are frequently struggling with issues such as communication and relationship difficulties, bullying and discrimination, low mood and anxiety and a number also self-harm. These experiences are often linked to a young person's gender identity. In our experience a young person is optimally supported when GIDS and the local CAMHS work in partnership. We support this by joining local network meetings, where we can participate in multi-agency discussions and supervision, for example to professionals providing psychotherapy, around gender issues. We can also provide literature and further information relevant to gender identity and the young person we are seeing.

As the local service we believe that the local CAMHS is best placed to monitor risk such as self-harm and suicidal ideation. CAMHS are also in the best position to provide more regular support to the young person and their families. If the referral to GIDS is not being made by CAMHS, and if there is identified risk, we request that a concurrent referral is made to CAMHS as well as to our service. If this has not already been done. We will be unable to accept referrals with identified risk without ongoing CAMHS involvement or a referral to CAMHS.'

629. In a letter dated 13 March 2017, to Patient C's GP, GIDS stated:

> *'….. We aim to see new referrals within 18 weeks. However due to a very large increase in referrals we currently have a waiting list of about 9 months.'*
>
> and
>
> *'Therefore we would be grateful if you could refer [Patient C] to their local CAMHS.'*

630. On 30 May 2017, Patient C's GP wrote to CAMHS asking them if they could arrange to see Patient C as advised by GIDS.

631. In a letter dated 17 July 2017, CAMHS wrote to Patient C's GP advising that they assessed Patient C on 3 July 2017.

632. The Tribunal had regard to an email dated 17 October 2016 from Patient C's mother to Dr Webberley. In this, Patient C's mother stated:

> *'I have a 10 year old ftm has been living as a boy since the end of May when he 'came out'. Going through puberty pretty early, is in between Tanner stage 1 and 2. Breasts began growing at age 9. We have been given a 10 month waiting time at the Tavistock'*
>
> and
>
> *'I feel like giving up though as I'm not getting anywhere! I'm playing amateur therapist at home in the meantime! I am in contact with our post adoption services but its slooooow..still waiting for a worker to be allocated to do an assessment of need…but even they have admitted already they dont really know how to help us.. .they think the Tavistock has the best CAMHS team...'*

633. The charge against Dr Webberley is that '..services already engaged in Patient C's care at the Tavistock'

634. The evidence before the Tribunal established that 'the Tavistock' was not engaged in Patient C's care before Dr Webberley ceased to practise. The information which Patient C's mother had elicited from 'the Tavistock' as to the waiting time was not elicited during a period when 'the Tavistock' was engaged in Patient C's care. It therefore found paragraph 5(j)(iii) of the Allegation not proved.

Paragraph 6

6. In treating Patient C as set out at paragraph 5 above, you:

a. failed to adhere to the following professional guidelines:

i. Endocrine Society Professional Guidelines (2009);
ii. World Professional Association for Transgender Health Standards of Care (7th Edition);

635. The Tribunal considered paragraphs 6(a)(i) and (ii) together.

636. The Tribunal was mindful that paragraphs 6(a)(i) and (ii) of the Allegation, which relate to Patient C, are expressed in similar terms to paragraphs 2(a)(i) and (ii) (Patient A) and paragraphs 4(a)(i) and (ii) (Patient B) of the Allegation. The patients are different, but the principles which the Tribunal considered and upon which it relied in order to reach its determination are the same. Insofar as the reasoning in its determination in respect of paragraphs 2(a)(i) and (ii) and 4(a)(i) and (ii) of the Allegation is not exclusive to Patient A or Patient B, the Tribunal relies upon those in relation to paragraphs 6(a)(i) and (ii).

637. It therefore finds paragraphs 6(a)(i) and (ii) of the Allegation not proved.

Paragraph 6

6. In treating Patient C as set out at paragraph 5 above, you:

b. knew or ought to have known you were acting outwith the limits of your competence as a General Practitioner with a special interest in gender dysphoria.

638. The Tribunal was mindful that paragraph 6(b) of the Allegation, which relates to Patient C, is expressed in similar terms to paragraphs 2(b) and 4(b) of the Allegation, which relate to Patient A and Patient B respectively. The patients are different, but the principles which the Tribunal considered and upon which it relied in order to reach its determination are the same. Insofar as the reasoning in its determination in respect of paragraphs 2(b) and 4(b) of the determination is not exclusive to Patients A or B, the Tribunal relies upon it in relation to paragraph 6(b).

639. It therefore finds paragraphs 6(b) of the Allegation not proved.

CQC – Dr Matt Limited

Paragraph 7

7. On the dates set out in Schedule 1, you inappropriately prescribed an increased dose to Patient D through a pharmacy website without any evidence that the change in dose was correct.

640. There were before the Tribunal copies of three 'online surgery' medication order forms completed by Patient D, dated 11 June 2016, 5 August 2016 and 23 September 2016. The order for the medication set out in Schedule 1 was contained in the third order. The second order, placed on 5 August 2016, was authorised by Dr Webberley. This included an order for 500mg tablets of metformin. The third order, placed on 23 September 2016, was also authorised by Dr Webberley. This included the 850mg metformin referred to in Schedule 1.

641. The Tribunal notes that, at the material time, Patient D was visiting the UK from abroad and required the medication to tide her over while she was in the UK.

642. Patient D requested 850mg metformin. There is no evidence before the Tribunal to indicate why Dr Webberley authorised that increase from 500mg to 850mg metformin.

643. In his report, dated 6 June 2018, Dr O stated:

> *'In my opinion, I would take issue with the prescribing of metformin 850mg at the third consultation. Dr Webberley had previously prescribed 500mg and I cannot find any information to suggest that [Patient D] had had her dosage of metformin changed. The normal maximum daily dose of metformin is 2000mg though 2400mg can be prescribed. However what I would say is that by prescribing 850mg without evidence that this change was correct Dr Webberley increased the daily dose of metformin for [Patient D]. In my opinion this was a significant change and could have put [Patient D] at risk.'*

644. During his oral evidence, Dr O acknowledged that doctors have to, to some degree, trust their patients and the reliability of the information they provide.

645. In her evidence, Dr Webberley explained how the online system worked. She said that when a request is submitted, it is filtered through the system and sits in an inbox which she would then access and review. Dr Webberley went on to say that there is an entry in the records which states 'awaiting review' and that would mean that she had some questions about the order placed by Patient D. Dr Webberley said that there would have been some discussion before she agreed to authorise the dose but the records placed before the Tribunal were incomplete. She told the Tribunal that Dr Matt Limited's online record system was managed and maintained by a third party. Dr Webberley told the Tribunal that she would not have agreed to increase the dose without having had some discussion with Patient D and that she was confident that, as per her usual practice, she would have done so on this occasion.

646. In her witness statement at paragraphs 14 – 15, Dr Webberley stated:

> *'14. Metformin is a medicine used to lower blood sugar in patients with diabetes. Patient D was initially prescribed 500mg tablets and then this was increased.*

15. From the records we have in our possession, there is no documentation of the rationale for the dose increase. However, in this situation when the request is placed in 'review' I would have sought more information to discuss the dose.'

647. The Tribunal was provided with a chronology from Dr Webberley's legal representatives, setting out the steps taken by the GMC to obtain the online records of Dr Matt Limited. In the chronology were the following entries of inquiries made by the GMC with Dr Matt Limited and with Etail in relation to records held.

'02/07/21 Email from CQC confirming again that they have no records from inspection of Matt Limited, they also don't have a record of a meeting on 25 January 2017. Advised may have electronic information and will review and back to you us'

14/07/21 Email from DMC addressing questions direct from case manager and answering as follows:
Dr Matt Limited was closed as an entity. Staff at DMC have repeatedly tried and failed to contact Etail - this was the provider of the clinical record system to Dr Matt Limited, where the detail of the two cases will have been recorded. We think that as an entity Etail may no longer be in existence. We are investigating this possibility.
We understand the legal nature of the request and the urgency. We did not hold the record keeping system, which I understand was run and owned by Etail. We do not have access to the clinical record system and as above, we have been trying to secure the details from the entity that may have been dissolved.
We are working on the request everyday. I will update you as soon as we understand our position whatever the findings of our investigation to secure the details requested.

'4/8/21 Etail respond the GMC via email confirming the following:
We closed down the Dr Matt site in the first quarter of 2017, and all (or most of) the patient data, orders and 'messages' between doctor and patient were passed to DMC Healthcare during this time. Our contract officially ended at the end of April 2017, and all data would have been deleted within 3 months of this date. Unfortunately we haven't got a record of exactly when this was done.'

648. In his closing submissions on behalf of Dr Webberley, Mr Stern argued:

- The email of 14 July 2021 clearly states that Dr Matt Limited 'did not hold the record keeping system'. It follows that the CQC did not obtain the patient records. It is clear that they obtained the admin records – this is obvious on its face, as accepted by Dr O and by virtue of the person obtaining the so-called records using the admin entry to the system. That chronology and the emails set out within are agreed evidence.

- That when Dr Webberley was provided with the material she made it clear in 2018 that the communications and patient records were missing. The GMC made no effort to obtain the records until 2021. A reasonable investigator

could and should have obtained a statement in 2017 from Dr Matt Limited or DMC dealing with the patient records in the light of the centrality of them to the GMC's case.

649. In the light of this chronology and the emails therein set out, the Tribunal was not satisfied that the GMC had managed to obtain all the relevant patient records.

650. The Tribunal reflected that if there was a review of the prescription sought by Patient D, this would have been prior to Dr Webberley signing off the prescription. The Tribunal is not satisfied that there was no such review in the absence of evidence that the GMC obtained all relevant patient records. The GMC has therefore not established that the increase in the dose was not clinically indicated. Likewise, Dr Webberley is unable to provide any evidence to show why she authorised the increase in the dose. However, the burden is on the GMC to prove its case and it has not done so. The Tribunal has therefore found paragraph 7 of the Allegation not proved.

Paragraph 8

8. On 26 August 2016, you dealt with Patient E's medication request made through a pharmacy website and you:

a. failed to:

~~i. adequately assess Patient E in that you did not seek further details of~~:

~~1. their symptoms~~;
Withdrawn following a successful Rule 17(2)(g) application

~~2. why they thought they had a STI~~;
Withdrawn following a successful Rule 17(2)(g) application

ii. refer Patient E to a Genito Urinary Medicine clinic for further investigations and/or tests;

iii. provide follow up advice in that you did not advise Patient E to attend at a GUM clinic in the event that they were suffering from a STI;

651. The Tribunal has considered paragraphs 8(a)(ii) and (iii) together.

652. There was before the Tribunal, a copy of the 'online surgery' medication order form completed by Patient E, dated 26 August 2016. This was for doxycycline (28 capsules, 100 mg). The health questionnaire, completed by and associated with Patient E's order, indicates that Patient E gave as his reason for requesting the medication "sexually transmitted disease" 'STD' (otherwise known as sexually transmitted infection 'STI').

653. The Tribunal had regard to an email from Patient E to the online surgery, dated 27 August 2016, in which Patient E stated:

> *'To whom it may concern*
>
> *I made a request for Doxycycline tablets, and received an email from the team stating that the doctor would like to ask a few more questions.*
>
> *However, I am unable to log into your online account, and as well i have left a few voice messages on your 0800 contact number.*
>
> *I would be most grateful if someone could ring from your team to discuss any query further on [redacted], thank you. Thank you'*.

654. On 30 August 2016, at 08:54, a member of staff of the online surgery forwarded Patient E's email dated 27 August 2016 to Dr Webberley. The member of staff stated:

> *'HI helen,*
>
> *This patient has responded to you about 12 hours back and looks to be in agony from his emails. Can you please revert back to him quickly.'*

655. Subsequently, as can be seen from the evidence provided, Dr Webberley authorised the prescription for the medication.

656. In his report of 6 June 2018, Dr O opined:

> *'a reasonably competent GP when given this diagnosis would have said to Patient E that they should attend a Genitourinary Clinic where appropriate tests and investigations could be undertaken so that the appropriate treatment could be given for the infection.'*
>
> *'a reasonably competent GP would not treat a STD "blind" with antibiotics because of the need to ensure that the right treatment be given for the infection present.'*
>
> *'given that Dr Webberley knew that Patient E had an STD this failure to ensure adequate tests and investigations was seriously below the expected standard putting Patient E at risk of getting inappropriate treatment (and of any sexual partners not been given treatment as necessary).'*

657. During his oral evidence to the Tribunal, Dr O expressed a number of concerns including that there appeared to be no information as to why Patient E thought he had a STD, and that there was no further inquiry made by Dr Webberley as to whether or not that was an appropriate diagnosis. Dr O went on to state:

'it was my opinion that given Patient E had a sexually transmitted – or had stated that he had a sexually transmitted disease, it would have been appropriate to refer him to his local genitourinary clinic where the appropriate tests could have been undertaken.'

658. He added that in general practice, if a patient presented with the possibility of having such a condition, they would be referred to a Genito Urinary Medicine (GUM) Clinic where the appropriate diagnosis could be made and appropriate treatment given.

659. The Tribunal was informed by Mr Stern that Dr Webberley admitted in her Rule 7 response that she did not refer Patient E to a GUM Clinic. However, in her witness statement of 26 August 2021, Dr Webberley stated:

'This email was retrieved from my own email records and was provided to the GMC by me. It was not within the records obtained by the CQC at the time of the inspection.

The outcome of this telephone consultation would provide the extra information with regards to their history, their symptoms and reasoning as to why the patient were seeking help for an STI. However, the record of this call and any further emails are not available in the admin records obtained by the CQC.

Some patients seek treatment from an online pharmacy because they have been informed they are a recent contact of someone with a diagnosed STI and have been advised to get a course of treatment. Some patients seek online treatment following a notification that they have had a positive test from their GP or local GUM clinic. Some patients have symptoms and seek interim treatment while they wait for an appointment at the GUM clinic.

I cannot recall now whether I advised Patient E to attend a genito-urinary clinic or not. I have extra expertise and training in sexual health and genito-urinary medicine (GUM) and am very aware of the indications for referral.

From the information available, I do not know what follow up advice was given to this patient or whether or not that involved advice to attend a GUM clinic. Not all patients require attendance at a GUM clinic, for example if they have had a positive test from a GP or GUM clinic or from a home testing kit.

As above, we do not have the clinical records for this patient and therefore I cannot see what I recorded at the time, and I cannot now remember. I would have recorded all relevant clinical advice that I had given.

Doxycycline is the recommended treatment for Chlamydia infection and non-specific urethritis. As this was the medication I prescribed, my assessment must have indicated this medication.

> *As above, we do not have the medical records for this patient. However, the fact that I prescribed Doxycycline would not have prevented me from also referring this patient for further tests if they had been indicated. It would not be good practice to withhold treatment pending any onward referral or further testing at a GUM clinic, if that was necessary.'*

660. Dr Webberley contends that the records provided by the CQC are incomplete and that she cannot recall what advice she gave to Patient E. She said that a complete trail of the records may have revealed what information she received from Patient E and/or any advice she gave to him. Indeed, Dr Webberley makes the unchallenged point that Patient E's email dated 27 August 2016 was adduced by her and that it was missing from the online records for Dr Matt Limited, reviewed by the CQC. On that basis, Dr Webberley posits that other emails between her and Patient E may have disclosed what information she received from Patient E and what advice she gave to him. Dr Webberley informed the Tribunal of a number of scenarios in which a patient might request medication for a STI from an online pharmacy, and this may include already having a diagnosis of a STI or awaiting an appointment at a GUM Clinic.

661. The GMC has not provided any evidence to suggest that Patient E did not already have a firm diagnosis of STI, or that he was waiting to be seen at a GUM Clinic. The GMC relies on the evidence of Dr O, which in turn, is based on the incomplete information provided by the CQC.

662. The Tribunal noted that these events took place some five years ago and therefore it will be difficult for Dr Webberley to recall accurately what transpired during this exchange of communication with Patient E. However, the Tribunal has taken into account that Dr Webberley is an experienced GP, having held various appointments since 1996. She has practice experience and qualifications relevant to the management of STIs in primary care. As STIs are a common presentation in primary care settings, GPs are familiar with the standard approach to referral and treatment of patients presenting with such. The Tribunal was therefore of the view that it was highly improbable that Dr Webberley would have simply approved the online request for the medication without reassuring herself as to the accuracy of the diagnosis of STI, or advising Patient E to go to a GUM Clinic, if that were considered necessary.

663. The Tribunal has therefore concluded that the GMC has not discharged its burden of proof. It found paragraphs 8(a)(ii) and (iii) of the Allegation not proved.

~~iv. record your:~~

~~1. assessment of Patient E as set out at paragraph 8ai above;~~ Withdrawn following a successful Rule 17(2)(g) application

~~2. referral of Patient E to a GUM as set out at paragraph 8aii above;~~ **Withdrawn following a successful Rule 17(2)(g) application**

~~3. follow up advice to Patient E as set out at paragraph 8aiii above;~~ **Withdrawn following a successful Rule 17(2)(g) application**

Paragraph 8

8. On 26 August 2016, you dealt with Patient E's medication request made through a pharmacy website and you:

b. prescribed 'Doxycycline 100mg 2 daily for 2 weeks' to Patient E which was not clinically indicated because you did not:

~~i. adequately assess Patient E as set out at paragraph 8ai above;~~ **Withdrawn following a successful Rule 17(2)(g) application**

ii. refer Patient E for further investigations as set out at paragraph 8aii above.

664. As a consequence of its finding in relation to paragraph 8(a)(ii) above, paragraph 8(b)(ii) of the Allegation is found not proved.

Paragraph 9

9. On 10 January 2017, during an ~~un~~announced CQC inspection of Dr Matt Limited, you were the Safeguarding Lead and you: **Amended by the Tribunal**

a. were unaware of the safeguarding policy;

b. had never seen a copy of the safeguarding policy.

665. The Tribunal considered paragraphs 9(a) and (b) together.

666. The Tribunal has had regard to the witness statement of Mr L, Inspector for the CQC, dated 21 November 2017. At paragraphs 12 Mr L states:

'From discussions with members of staff, including Dr Webberley, it became apparent that they were not aware of the safeguarding policy that was in place at the provider. The non-clinical staff at the provider had not undergone any safeguarding training. During the inspection we were directed to the providers safeguarding policy but none of the staff at the provider had ever seen this document. As Registered Manager, I

would have expected Dr Webberley to know exactly what is in the policy and to have a copy of it herself. Dr Webberley was also listed as the Safeguarding Lead at the provider therefore I would have expected her to have known the safeguarding procedure, inside out.'

667. In her witness statement at paragraphs 27 and 28, Dr Webberley states:

'I do not know which safeguarding policy the CQC inspection team were referring to. The inspectors attended the head offices of DMC Healthcare Limited and to my knowledge there was not a specific Dr Matt folder of information held at the DMC premises.'

'DMC is a very large organisation providing private and NHS dermatology, radiology and primary care services and presumably has many policies and protocols that cover their business. However, I do not know which one of those was shown to the inspectors on that day.'

668. During cross examination, Dr Webberley maintained this position stating when asked about being unaware of the safeguarding policy:

'This was tricky. I think I've explained this in my witness statement, so forgive me if I'm repeating myself, but the inspectors were in London because that's where the DMC head offices were, which was the registered address of the provider with the CQC. Myself, as the registered manager, was at my home in Wales, my PA was in Coventry and the Head of IT was in India. The difficulty was that the staff at DMC, "XX", I'll call her, was the Head of Operations for the whole of DMC. So, in all honesty, I don't know which safeguarding policy that they've been referred to here. I don't know whether it was a global policy for the whole of DMC, which was a huge organisation, or whether it was one that referred to some of their NHS practice, or some of the radiology, or dermatology, that they had on-site. To my knowledge, there wasn't a safeguarding policy that referred to Dr Matt at the premises and I certainly hadn't seen one. I didn't have one electronically or anything.'

She went on to state:

'I've just explained really. We were a small organisation, and our policy was if there's a problem it comes to me. In the CQC, the final report, it said – and this is on page 417, C2: 'The clinician had received safeguarding training relevant to their role…' I know that in terms of what is required, or what is mandatory, I know as a clinician that I need to have safeguarding training. I certainly wouldn't take issue with that, but in terms of if you like the piece of paper and policy, I'm not sure that there was a piece of paper.'

669. The Tribunal had regard to the wording of the allegation and considered the meaning of the words 'the safeguarding policy' in paragraphs 9(a) and (b). It determined that it must

refer to the policy provided to the CQC's inspectors by the member of staff at DMC Limited, (the company which owned Dr Matt Limited). There was no evidence of any other written safeguarding policy. The Tribunal has not been provided with a copy of that policy document. It cannot therefore know whether that policy document was DMC Limited's own policy or whether it was adopted by Dr Matt Limited as their own, or conceivably a Dr Matt Limited policy. However, the Tribunal had no reason to doubt Dr Webberley's evidence that, so far as she was concerned, Dr Matt Limited did not have a written safeguarding policy and that if safeguarding issues arose, members of staff would refer the issues to her as the Registered Manager and Safeguarding Lead at Dr Matt Limited.

670. The Tribunal noted that the CQC did not request that Dr Matt Limited's safeguarding policy be made available to them on their inspection (in contrast to other policies in which it was interested), and that Dr Matt Limited did not have a personal presence at the inspected premises which were DMC Limited's registered offices. Dr Matt Limited's employees worked remotely.

671. The Tribunal acknowledged the obligation of Dr Matt Limited, a CQC registered health or social care provider, to have a safeguarding policy. It considered that an informal unwritten understanding concerning would not constitute an appropriate policy for Dr Matt Limited.

672. On the basis that 'the safeguarding policy' referred in paragraph 9 of the Allegation means the policy which was handed to the CQC inspectors by a member of staff at DMC, Dr Webberley has admitted that she was unaware of that policy and had never seen a copy of it.

673. The Tribunal therefore finds paragraphs 9(a) and 9b) of the Allegation proved.

Royal College of General Practitioners ("RCGP")

Paragraph 10

10. On 9 May 2017 you submitted to the Interim Orders Tribunal ('the IOT') a:

a. signed witness statement in which you stated that you had been a member of the RCGP since 1996; **Admitted and found proved**

b. copy of your Curriculum Vitae which stated that you had been a member of the RCGP since 1996.

674. The Tribunal was provided with two versions of the Dr Webberley's CV. "CV Version 1" was adduced by the GMC in exhibits C2 and C12; it was also adduced in Dr Webberley's bundle at exhibit D1. "CV Version 2" is adduced by the GMC in exhibit C54, apparently captured from the Gender GP.com website. The Tribunal relied on CV Version 1 as the relevant CV. Although CV Version 1 is undated, the Tribunal was advised that this was prepared in or after March 2017 as it listed the following posting '"Webberley H. Transgender

AMA. The New Reddit Journal of Science. https://red.it/5z4et8 March 2017" in a section titled "PRESENTATIONS AND PUBLICATIONS."

675. CV Version 1 has a section entitled "POSTGRADUATE QUALIFICATIONS" There are 14 postgraduate qualifications listed in that section, 12 of which are diplomas or certificates, letters of competence or e-learning. There are two "memberships" in that section: "Membership of the Royal College of General Practitioners, London, 1996" and "Membership Faculty of Reproductive and Sexual Health, 2007. CV Version 1 does not have a section listing her affiliations (that is, membership organisations to which she belonged).

676. Dr Webberley did not 'state' in her CV that she submitted to the IOT that she had been a member of the RCGP since 1996: she merely listed Membership of the RCGP as a postgraduate qualification. This was a statement which she was perfectly entitled to make, having sat and passed the examination on 11 December 1996.

677. The Tribunal therefore found that Dr Webberley did not state that she had been a member of the RCGP since 1996. It therefore found paragraph 10(b) of the Allegation not proved.

Paragraph 11

11. You have never been a member of the RCGP.

678. During her oral evidence, Dr Webberley told the Tribunal that she recalled being a paid-up RCGP member at the time of passing the MRCGP examination, but that she allowed her membership to lapse soon afterwards.

679. The Tribunal noted that the GMC had made inquiries with the RCGP and in an email response dated 9 April 2019, an officer of the RCGP stated *'I can confirm that Dr Webberley is not, and has never been, a Member of the Royal College of General Practitioners.'*

680. In a letter to the GMC, dated 12 April 2019, the officer at the RCGP stated:

> *'On 19 November 2012, Dr Webberley created a non member data file with the RCGP. Drs who are not members of the RCGP can do this access the online educational tools that we offer'* [sic]
>
> *'Dr Webberley was contacted on by email on 12 August 2013 as part of the standard non member recruitment campaign that we carry out. Dr Webberley did not respond to this invitation.'*

681. The Tribunal considered it relevant to its findings that the officer at the RCGP appeared to have had access to the records; by contrast Dr Webberley was reliant on her memory of events that occurred some twenty five years ago.

682. The Tribunal was of the view that Dr Webberley would not have needed to create a non-member data file with the RCGP in 2012 if she was a fully paid-up member at that time, nor would the RCGP have contacted Dr Webberley in 2013 as part of their non-member recruitment campaign if she were a member at that time.

683. It therefore determined that Dr Webberley has never been a member of the RCGP and found paragraph 11 of the Allegation proved.

Paragraph 12

12. You submitted information to the IOT which was untrue.

684. At paragraphs 3 and 4 of her witness statement to the Interim Orders Tribunal ('IOT'), dated 8 May 2017, Dr Webberley stated:

'3. I provided a detailed response to the GMC [BP 21-155]. The summary of that response is as follows:
4. In response to the allegation that I do not have adequate training, I have been qualified since 1992 and have been a member of the Royal College of General Practitioners since 1996. I have a number of additional diplomas and have worked in a variety of relevant clinical areas.'

685. The Tribunal was mindful of its finding in relation to paragraph 11 above, and as a consequence, found Dr Webberley's statement that she was a member of the RCGP since 1996 to be inaccurate.

686. It therefore found paragraph 12 of the Allegation proved.

Paragraph 13

13. You knew that the information provided in the documents referred to at paragraph 10 above was untrue.

687. The Tribunal was not provided with BP 21-155, but it can be inferred from the wording in paragraph 4 of her witness statement dated 8 May 2017, as set out above, that Dr Webberley was referring to her qualifications. *She stated 'I have been qualified since 1992 and have been a member of the Royal College of General Practitioners since 1996. I have a number of additional diplomas…'*. The Tribunal considered that Dr Webberley was stating literally that 'member of the Royal College of General Practitioners' was one of her diplomas.

688. Such an inference is consistent with Dr Webberley's oral evidence at cross examination during which she stated:

Question: '10a alleges you signed a witness statement that you had been a member since 1996 and that is admitted - so focus is you had been a member'

Answer: 'In paragraph 4 I am responding to training - I was responding - perhaps wrong to do that - what I mean is I have achieved membership - I have the exam - not being a paid up member doesn't mean the exam goes away.'

689. Dr Webberley's assertion that her use of MRCGP as a post-nominal was to declare that she had passed the RCGP examination, commonly referred to as 'the membership examination', rather than to claim she was a paid up member of RCGP, is consistent with her CV Version 2. Thus, 'Membership of the Royal College of General Practitioners, London, 1996' in CV Version 2 appears in a section titled 'Postgraduate education' which, like the similarly titled section 'POSTGRADUATE QUALIFICATIONS' in CV Version 1, comprises a list of diplomas, certificates etc. CV Version 2, unlike CV Version 1, has a section titled 'Affiliations'. The only item listed under 'Affiliations' in CV Version 2 of Dr Webberley's CV is 'Full Membership of the World Professional Association of Transgender Health (WPATH)'. Membership of the Royal College of General Practitioners is not listed.

690. If Dr Webberley's use of MRCGP as a post-nominal was intended to claim membership of the RCGP, as opposed to having passed the RCGP membership examination, it might be expected that she would have listed MRCGP as an affiliation in CV Version 2.

691. The Tribunal had regard to a record of a telephone conversation on 10 April 2019 between the GMC and the RCGP. It is recorded:

'I called to check whether the doctor may have used a former name to apply for membership of the College.
Mr HH stated that they use a doctor's GMC number as the UID for their database and that, as such, any change of name would not affect the results of any search.
I asked him to check back to the 1996 period where ABUHB had indicated that they understood she may have been a member.
Mr HH stated that Dr Webberley had sat the RCGP exam on 11/12/1996, but that she had never become a member and had therefore never been entitled to use the post-nominal MRCGP.
He stated that the RCGP had written to the doctor in 2017 to ask her to stop using the post nominal MRCGP as she was not entitled to do so.'

692. The Tribunal also had regard to the letter alluded to by Mr HH in which he states:

'As Assistant Honorary Secretary of the College I must inform you that you are not currently a member of the College. Please note that passing the MRCGP examination does not entitle you to use the letters MRCGP after your name unless you are a member in 'good standing' (e.g. by paying your annual subscription). I would be grateful, therefore, if you would remove the letters from the website.'

693. The RCGP letter to Dr Webberley is dated 19 April 2017, some 19 days before Dr Webberley's statement to the IOT of 8 May 2017.

694. Dr Webberley, in her evidence, admitted having received the RCGP letter of 19 April 2017. She went on to state:

> *'Throughout my career, I have always used MRCGP as a post-nominal and have often stated that I have Membership of the Royal College of General Practitioners. I have never intended for this to be taken as an indication of being a yearly subscriber to the College, but simply used the term to indicate my level of qualification and my success in passing the membership exam. The exam is still called the MRCGP exam, and the qualification is known as gaining the Membership of the Royal College of GP's exam.'*

695. Dr Webberley also stated that, upon receipt of the RCGP letter, she removed MRCGP from her letterheads and email signatures and also informed and requested third-party websites to do to do the same. Further, Dr Webberley stated:

> *'On 24 April 2017 I had the PACE interview with HIW and on 25 April 2017 the Health Board Reference Panel suspended me from Medical Performers List. On 28 April 2017 I received notice of the IOT hearing to be held on 09 May 2017. All of these things were very new to me and I do not think I gave the RCGP letter the due regard that it deserved.'*

696. In her oral evidence to this Tribunal, Dr Webberley stated words to the effect:

> *'I did receive that letter. That was in April when my whole world turned upside down - I had ABUHB - ref panel - IOT. Yes, letter dated 19 April 2017 - don't know when I received it - overwhelmed - sorry for error.'*

697. In the circumstances, the Tribunal determined that Dr Webberley did not know that the information provided to the IOT was untrue. The Tribunal therefore found paragraph 13 of the Allegation in relation to paragraph 10(a) not proved.

Paragraph 14

> 14. Your actions as described as paragraphs 10 - 12 were dishonest by reason of paragraph 13.

698. By reason that the Tribunal has found paragraph 13 not proved, it finds paragraph 14 of the Allegation in relation to paragraphs 10(a), 11, 12 and 13, not proved.

Work Details Form

Paragraph 15

~~15. You completed and signed a Work Details Form ('the WDF') on 5 March 2017 in which you failed to declare that you were sub-contracted to provide medical services to Frosts Pharmacy until 24 May 2017.~~
Withdrawn following a successful Rule 17(2)(g) application

Paragraph 16

~~16. When you completed the WDF, you knew you were sub-contracted to provide medical services to Frosts Pharmacy until 24 May 2017.~~
Withdrawn following a successful Rule 17(2)(g) application

Paragraph 17

~~17. Your conduct as described at paragraph 15 was dishonest by reason of paragraph 16.~~
Withdrawn following a successful Rule 17(2)(g) application

Suspension from the Medical Performers List

Paragraph 18

18. On 25 April 2017 you were suspended from the Medical Performers List and you failed to notify Frosts Pharmacy of this.

699. The Tribunal had regard to the chronology of events in relation to this allegation. The Reference Panel of the ABUHB convened on 25 April 2017 and determined to suspend Dr Webberley from the Medical Performers List (MPL) with immediate effect. Dr Webberley was not present at the Panel meeting. On 28 April 2017, Dr Webberley was notified of the decision.

700. At paragraphs 23 to 26 of his witness statement dated 22 September 2017, Mr R, Managing Director of FPL stated:

'I was made aware that Dr Webberley had been suspended from the MPL by the GMC following my writing to them to seek further information about their investigation. I understand from the advice given to me by the GMC that a doctor does not have to be included on the MPL for them to operate within private services.

I understand that conditions were also subsequently imposed on Dr Webberley's registration by the Interim Orders Tribunal of the Medical Practitioners Tribunal Service on 10 May 2017. I received an email from Dr Webberley the following day at 9.52am to advise me of this. This issue was discussed at a clinical governance meeting at Frosts on the same date. ….

Dr Webberley stopped providing medical services to Frosts on 24 May 2017. Up until this point Dr Webberley was logging in and looking at information but was not prescribing to any patients. We have since employed another doctor to provide medical services for Frosts.

Our major concern in respect of Dr Webberley was the reputational risk to Frosts by way of its association with her and some of the negative publicity she was attracting through her transgender work. Dr Webberley was our named GP and her profile was raised higher and higher through this work. We were building a respected brand and therefore did not want our service to be negatively affected by this. We asked Dr Webberley not to prescribe in the future whilst there was ongoing involvement with the GMC but she decided to terminate her services anyway.'

701. In her witness statement dated 26 August 2021 Dr Webberley states *'I did not inform Mr R regarding my status on the Medical Performer's List.'*

702. The GMCs case is that Dr Webberley had a duty to inform FPL that she had been suspended from the MPL, in accordance with paragraph 76 of GMP, which states:

'76 If you are suspended by an organisation from a medical post, or have restrictions placed on your practice, you must, without delay, inform any other organisations you carry out medical work for and any patients you see independently.'

703. The Tribunal noted that undertaking work for FPL did not require Dr Webberley to be on the MPL.

704. The Tribunal accepted that at the time of her suspension from the MPL in April 2017, Dr Webberley was not in fact undertaking any work for FPL.

705. However, the GMC adduced in evidence, data taken from FPL's IT system records on 18 May 2017. This revealed that Dr Webberley's credentials were used to log onto to the FPL system. It also showed that Dr SS was logging onto the system at the same time. On analysis, the entries in the data log showed Dr Webberley accessed the system on three separate occasions lasting around a minute each and that during these logins, she entered:

'questionnaire: 87217 declined; order: 146453 set to query; 'Inserted a new patient note: Please describe symptoms, usage and how effective they are.'; `: 87217 declined order: 146453 set to query' questionnaire: 87216 declined; order: 146448 set to query' 'Inserted a new patient note: more info pls'.'

706. Dr Webberley accepted that on 18 May 2017, she XXX had travelled abroad for a vacation and that she had logged onto the FPL IT system while XXX in Malaga Airport.

707. On this basis, the Tribunal determined that Dr Webberley had carried out medical work for FPL on 18 May 2017.

708. Taking the above evidence into account, the Tribunal finds that Dr Webberley did fail to notify FPL that she had been suspended from the MPL. It therefore finds paragraph 18 of the Allegation proved.

Paragraph 19

> 19. You knew that you were required to inform Frosts Pharmacy of your suspension from the Medical Performers List.

709. Dr Webberley's evidence was that:

- she had essentially stopped undertaking any work for FPL in January 2017. That work was thereafter undertaken by Dr SS.
- she understood that the MPL related to NHS work only and as a result she did not feel that there was a requirement for her to notify FPL of her suspension from the NHS Medical Performers List;
- she was unaware of paragraph 76 of GMP or that paragraph 76 imposed the obligation on her recited above. She also pointed to the fact that GMC Counsel when opening the case stated that she was not strictly required to inform FPL. Mr Stern, on her behalf also referred to GMC Counsel's closing observation that she was not required by law to inform FPL and that she could continue to provide medical services outside the NHS in Wales.

710. As mentioned, Dr Webberley accepted that, although her involvement with FPL ended in January 2017, she did provide some services to FPL after that date. She explained that on 18 May 2017, she XXX had travelled abroad for a vacation and that she had logged onto the FPL IT system while XXX in Malaga Airport. The context of that vacation was that Dr Webberely was undergoing a number of investigations into her professional life.

711. The Tribunal also noted that on 11 May 2017, Dr Webberley did inform FPL of her IOT conditions imposed on her registration on 10 May 2017.

712. The Tribunal determined that, although Dr Webberley was under an obligation to inform FPL of her suspension before or when she logged onto the FPL website on 18 May 2017, she did not then understand that she had that obligation. It accepted her reasons for that erroneous understanding set out above. The Tribunal noted that this was Mr R's understanding as well.

713. On the basis of the evidence before it, the Tribunal determined that Dr Webberley did not know she was required to inform FPL of her suspension from the MPL. It therefore found paragraph 19 of the Allegation not proved.

Paragraph 20

20. Your conduct as described at paragraph 18 was dishonest by reason of paragraph 19.

714. The Tribunal has found paragraph 19 of the Allegation not proved. On the basis of its findings in relation to paragraph 19, the Tribunal determined that Dr Webberley's conduct was not dishonest. It therefore found paragraph 20 of the Allegation not proved.

Aneurin Bevan University Health Board

Paragraph 21

21. In July 2017 a review was initiated by Aneurin Bevan University Health Board ('the Health Board') into your on-line prescribing practices ('the Review') and you:

a. repeatedly frustrated the Health Board's attempts to carry out the Review in that you:

i. consistently challenged the Review where there was no basis to do so, in that you questioned the:

1. terms of reference;

2. competence of the investigators;

3. training of the investigators;

4. the proposed CQC methodology;

715. The Tribunal considered paragraphs 21(a)(i)(1 – 4) together.

716. The Tribunal had regard to the chronology of events relating to this allegation and the extensive exchange of correspondence between ABUHB and Dr Webberley and her Solicitors, Ridouts, leading up to the visit by the investigators on 5 October 2017. The decision of the Reference Panel of the ABUHB on 25 April 2017 was:

1. To suspend Dr Webberley from the MPL with immediate effect.
2. To commission an independent expert review in relation to Dr Webberley's participation in transgender care and also online prescribing.

717. An exchange of correspondence then began between Dr Webberley and ABUHB on 23 June 2017 when Dr Webberley's legal representatives wrote to ABUHB challenging the decision to suspend Dr Webberley from the MPL.

718. On 27 July 2017, ABUHB informed Dr Webberley that it was ready to proceed with the investigation into her online prescribing, having commissioned two professionals (a doctor

and a pharmacist), but was still seeking an independent professional to investigate the transgender care element of her work. ABUHB indicated that the investigation officers would be guided by a 2017 CQC model of investigation and asked Dr Webberley for her availability during the weeks commencing 7 August 2017 and 14 August 2017 for a visit to her place of work. On 31 July 2017, Dr Webberley confirmed her availability in a letter dated 31 July 2017 addressed to Dr N and Dr OO at ABUHB. In this letter, Dr Webberley also asked a series of questions about the decision to suspend her from the MPL, some of which she felt she had asked before but were unanswered, and went on to ask a series of questions about the investigation, which included:

- What is the ABUHB investigating that is not already being investigated by GMC;
- What is the process for the investigation;
- What steps have been made in the investigation thus far;
- Who is the case manager;
- How will Drs OO and Dr N remain impartial in their investigation roles, given their other roles as Responsible Officer, appraiser etc which may give rise to conflicts of interest;
- Why it has taken three months to start the investigation;
- What are the terms of reference of the investigation (the issues to be investigated; the period under investigation; the timescale for completion);
- In what way are the investigators deemed to be independent, given that they are both employees of ABUHB;
- What training and experience have those involved in the investigation had in undertaking performance investigations;
- Have the investigators been given protected time to carry out the investigation;
- Why is the CQC methodology considered to be the appropriate given that her practice does not require CQC registration.

719. On 8 August 2017 Ridouts, on behalf of Dr Webberley, contacted ABUHB seeking a full response to Dr Webberley's letter to ABUHB of 31 July 2017.

720. On 18 August 2017 ABUHB wrote to Dr Webberley and stated *'we received a letter from your new Solicitor Ridouts on the 8th August 2017, which resulted in the 10th August being postponed on the basis that you required a response to your letter of the 31st July 2017 prior to the commencement of the investigation. On that basis we are now responding to your letter of the 31st July 2017 we are proposing to offer you the 22nd August 2017 for the investigation to commence.'* The letter also contained some responses to Dr Webberley's questions. In this letter ABUHB advised Dr Webberley that the terms of reference for the investigation are *'To investigate the quality and governance of the generic aspects of your online medical and prescribing services …'*.

721. On 21 August 2017, Ridouts contacted ABUHB to explain that Dr Webberley would not be available in the week of 22 August 2017 as she was experiencing stress. Ridouts asked what documentation the investigators would wish to see in order that Dr Webberley could

prepare for the investigation visit. Ridouts also again asked why CQC investigation methodology was being used, when CQC has no jurisdiction in Wales. Attached to this letter was a table containing 35 questions in respect of which Dr Webberley sought answers. This was followed by an email from Dr Webberley on 12 September 2017 to ABUHB asking for a reply to her 35 questions and ABUHB replied on the same day promising answers to those questions 'soon'.

722. ABUHB emailed Ridouts on 22 September 2017 in relation to the 'vast number' of questions asked by Dr Webberley in her letter of 21 August 2017 providing some answers. ABUHB also stated that dates to commence the investigation were being considered, having received proposed dates from Dr Webberley.

723. In response to an email from ABUHB dated 26 September 2017, Dr Webberley advised ABUHB she was available on 5 October 2017. On 29 September 2017, ABUHB wrote to Dr Webberley confirming the investigators would attend on 5 October 2017 and provided some details of the investigation visit to her premises.

724. On 6 October 2017, Dr BB (ABUHB investigator), wrote to Dr N, explaining that the investigation visit to Dr Webberley took place on 5 October 2017 but was terminated at an early stage. Dr BB explained this was because Dr Webberley posed again her questions about the CQC/NCAS methodology and the terms of reference (i.e. whether the investigation was of a service or of her performance), which she evidently felt remained unanswered. It is evident from this correspondence that the decision to terminate the investigation visit and to reschedule it once questions of methodology and terms of reference were resolved was made by the inspection team, not by Dr Webberley. Tabulated notes taken during that visit were appended.

725. Dr Webberley also wrote to ABUHB on 8 October 2017 stating:

'When the case investigators attended, it was not clear whether their brief was to:

- *Inspect my service*
- *Inspect me as a practitioner*
- *Investigate concerns about me*
- *Investigate concerns about my websites*

Dr BB rang you for clarification and I understand that you told him that the brief was to, 'investigate how I work within the service.' They were not utilising a Local Health Board or NCAS policy for investigation, instead they had in their possession an amended toolkit used by the CQC for the routine inspection of digital services. They had not had training in using this toolkit, and the questions therein had not been shared with me prior to the investigation.'

726. On 31 October 2017, ABUHB wrote to Dr Webberley stating that another investigation visit would take place on 7 November 2017 and that CQC methodology would be used. In this it stated:

> *'The terms of the investigation are as follows:*
>
> > *To investigate the governance process of your Welsh Prescribing Practice, including on-line Prescribing. The investigators will utilise the CQC Care Quality Commissioner's – Clarification of Regulatory Methodology: PMS Digital Healthcare Providers (March 2017) model of investigation to provide a structured approach to the investigation, focusing on the 5 key domains.*
> >
> > *Is your clinical practice:*
> > - *Safe?*
> > - *Effective?*
> > - *Caring?*
> > - *Responsive to people's needs?*
> > - *Well-led?'*

727. Dr Webberley responded on 2 November 2017 stating that insufficient notice had been given (seven days, not allowing for the time taken for the letter to be delivered) and reiterated her concerns about the terms of reference and methodology. On 3 November 2017 Dr Webberley advised ABUHB she had received their letter of 31 October 2017 on 2 November 2017. In her letter she stated that the proposed date of the visit on 7 November 2017 was not acceptable. Dr Webberley's claim of having been given insufficient notice was refuted by ABUHB on 27 November 2017.

728. In her evidence, Dr Webberley stated:

> *'I questioned the terms of reference because I was not clear what these were….'*
>
> *'The Health Board had asked two of their employees to carry out the investigation/review. I was not sure what experience they had had with online medicine provision and telehealth ... While I had no concerns at all that they were competent professionals, I did not know what competence or experience they had in Telehealth or digital medicine, or in carrying out investigations. I therefore questioned this as it was relevant to the material they may want to look at as part of the investigation or review.'*
>
> *'The investigators were instructed to use the CQC services inspection toolkit. I asked the CQC what training inspectors had" and "It was my understanding that the investigators had no training or experience in the use of this methodology and this is why I questioned it.'*

> *'The difficulty was not the CQC questions, but what the result of the findings would mean for me in terms of my suitability for inclusion on the Medical Performer's List'*
>
> *'What data needed to be collected during this new investigation, and how the data was going to be interpreted and how recommendations would be made was not clear to me and I was anxious about the impact that this would have on my ability to work.'*
>
> *'When the investigators came to my home, I was very pleased to finally get a chance to talk to someone. I do acknowledge that I 'offloaded' during this meeting. I remember being very upset and tearful, and I apologised for my emotional state. My intention was not to prevent progress to the review, but to simply make sure that the investigation was fair and that they came to the correct findings and recommendations.'*

729. The allegation here is that Dr Webberley repeatedly frustrated ABUHB's attempts to carry out the review. The Tribunal had regard to the original decision of the Reference Panel in April 2017, which was 'to commission an *independent expert* review in relation to Dr Webberley's participation in transgender care and also *online prescribing*.'

730. The Tribunal noted that Dr Webberley questioned various matters relating to the review instigated by the Reference Panel, including the terms of reference, the methodology to be applied, etc. She did so very early on following the decision of the Reference Panel in April 2017. However, it was not until July 2017 that ABUHB advised Dr Webberley that the review would be into her online prescribing and that it was still seeking an independent professional to investigate the transgender care element of her work. Having not been able to identify any person to undertake the investigation into Dr Webberley's transgender care work, because they were not qualified to do so, ABUHB appeared to widen the remit of the investigation, from that originally determined by the Reference Panel. In August 2017, ABUHB informed Dr Webberley that the terms of reference of the investigation were now *'To investigate the quality and governance of the generic aspects of your online medical and prescribing services'*.

731. Paragraph 21(a)(i) of the Allegation alleges that Dr Webberley challenged the Review where there was no basis to do so. The Tribunal determined that the matters raised by Dr Webberley in her correspondence could not properly be said to have *no basis* in the light of the fact that the Reference Panel commissioned an *independent expert* review in relation to her participation in (transgender care and also) *online prescribing*. Dr Webberley was seeking clarification of the apparent change of the terms of reference of the investigation, the methodology to be used, the training, experience and the independence of the investigators. The Tribunal determined that Dr Webberley was never provided with a full response to her questions. It determined that these were reasonable questions for Dr Webberley to raise, in the interests of openness and fairness, and answers to the questions would have enabled Dr Webberley to fully engage with and respond to the investigation.

732. In consequence, the Tribunal did not find that Dr Webberley's actions were designed to frustrate the review process nor that she repeatedly frustrated it. It therefore found paragraph 21(a)(i)(1 – 4) of the Allegation not proved.

Paragraph 21

21. In July 2017 a review was initiated by Aneurin Bevan University Health Board ('the Health Board') into your on-line prescribing practices ('the Review') and you:

a. repeatedly frustrated the Health Board's attempts to carry out the Review in that you:

ii. continued to challenge the Review as set out at paragraph 21ai above when investigators visited your house on 5 October 2017, preventing any progress to the Review;

733. The basis of this particular of the Allegation is the same as paragraph 21(a)(i). By reason of its findings in respect of paragraph 21(a)(i) above, the Tribunal found paragraph 21(a)(ii) of the Allegation not proved.

~~b. failed to advise the Health Board throughout the period of the Review of open GMC investigations against you.~~
Withdrawn following a successful Rule 17(2)(g) application

Paragraph 22

22. During the Review, you knew that you were:

a. the subject of open GMC investigations;

734. Dr Webberley accepted that she knew she was under an open GMC investigation at the time of the Review. The Tribunal therefore finds paragraph 22(a) of the Allegation proved.

~~b. required to inform the Health Board of ongoing GMC investigations.~~
Withdrawn following a successful Rule 17(2)(g) application

Paragraph 23

~~23. Your conduct asset out at paragraph 21b was dishonest by reason of paragraph 22.~~
Withdrawn following a successful Rule 17(2)(g) application

Gender GP

Paragraph 24

24. Alongside Dr SS, you operate and control the company known as Gender GP, through which you provided care and treatment.

735. Dr Webberley accepted that, at the material time, she operated and controlled the company known as GenderGP Limited through which she provided care and treatment. The Tribunal therefore finds paragraph 24 of the Allegation proved.

Paragraph 25

~~25. As the principal provider of the Gender GP website, offering hormonal treatment to children, you failed to appropriately reference:~~

~~a. the input of any accredited paediatrician/paediatric specialist;~~
Withdrawn following a successful Rule 17(2)(g) application

~~b. your safeguarding policy.~~
Withdrawn following a successful Rule 17(2)(g) application

Paragraph 26

~~26. On the governance page of the Gender GP website it states that 'all medical advice and prescriptions are provided by doctors working outside of the UK'.~~
Withdrawn following a successful Rule 17(2)(g) application

Paragraph 27

~~27. The operating method of Gender GP as set out at paragraph 26 above is motivated by efforts to avoid the regulatory framework of the United Kingdom, including regulation by the:~~

~~a. CQC;~~ Withdrawn following a successful Rule 17(2)(g) application

~~b. HIW;~~ Withdrawn following a successful Rule 17(2)(g) application

~~c. GMC.~~ Withdrawn following a successful Rule 17(2)(g) application

Conviction

28. On 5 October 2018 at the Mid Wales (Merthyr Tydfil) Magistrates' Court you were convicted, contrary to Section 11(1) of the Care Standards Act 2000, in that you did:

a. carry on or manage an independent medical agency, namely Online GP Services Limited, without being registered under Part 11 of the Care Standards Act 2000; **Admitted and found proved**

b. as a director of Online GP Services Limited, consent to that company carrying on or managing an independent medical agency, namely Online GP Services, without it being registered under Part 11 of the Care Standards Act, thereby committing an offence contrary to section 30(2) of the Care Standards Act 2000.
Admitted and found proved

29. On 3 December 2018 you were sentenced to pay a fine in the sum of £12,000.00.
Admitted and found proved

The Tribunal's Overall Determination on the Facts

736. The Tribunal made the following findings:

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

Patient A

1. Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

a. obtain an adequate medical history for Patient A, in that you failed to elicit information about:

i. Patient A's physical or psychosocial childhood;
Found not proved

ii. adolescent development;
Found not proved

iii. gender identification and development;
Found not proved

iv. any adaptions made to address gender incongruence;
Found not proved

v. mental health;
Found not proved

vi. self-harm or suicidal ideation and associated risk factors;

Found not proved

b. arrange for Patient A to be <u>**adequately**</u> examined prior to prescribing testosterone treatment, including:
Amended under Rule 17(6)

i. a physical examination to determine:

1. blood pressure; **Found proved**

2. weight development; **Found not proved**

3. final height assessment; **Found not proved**

4. bone health; **Found not proved**

5. an assessment to ensure a synchronised pubertal development with peers; **Found not proved**

ii. a psychological assessment to confirm a diagnosis of gender dysphoria;
Found not proved

c. prescribe clinically-indicated treatment to Patient A, in that testosterone:

i. was not appropriate for use in children of Patient A's age;
Found not proved

ii. was commenced without the input of an integrated multi-disciplinary team beforehand;
Found not proved

d. ensure it was feasible for Patient A to receive the correct dosage of testosterone as prescribed by prescribing a metered dispenser rather than in sachet form;
Found not proved

e. assess Patient A's capacity to consent to treatment;
Found not proved

f. in the alternative to paragraph 1e, record any assessment of Patient A's capacity to consent;
Found proved

g. provide adequate follow-up care to Patient A after initiating testosterone treatment in that you failed to:

i. arrange assessments to evaluate Patient A's response to testosterone treatment, including:

1. psychosocial development monitoring;
Found proved

2. physical development monitoring;
Found proved

3. laboratory testing;
Found proved

h. inform Patient A's GP of the medication you were prescribing to A;
Found proved

i. seek a psychological assessment after Patient A's mental health deteriorated;
Found not proved

j. adequately communicate with Patient A's other treating physicians at the Gender Identity Clinic at University College London Hospitals after you commenced testosterone treatment;
Found proved

k. maintain an adequate record of Patient A's treatment in that entries in records were:

i. infrequent;
Found not proved

ii. made by administrative staff;
Found not proved

iii. unclear as to who had made them;
Found proved

iv. made using email print-offs rather than an electronic record system;
Found not proved

l. engage in and / or with an adequately trained and specialist multidisciplinary or interdisciplinary team, in that you did not seek input before and during treatment from:

i. a paediatric endocrinologist;
Found not proved

ii. a mental health practitioner;
Found not proved

iii. LGBT and trans organisations which Patient A was attending.
Found not proved

2. In treating Patient A as set out at paragraph 1 above, you:

a. failed to adhere to the following professional guidelines:

i. Endocrine Society Professional Guidelines (2009);
Found not proved

ii. World Professional Association for Transgender Health Standards of Care (7th Edition);
Found not proved

b. knew or ought to have known you were acting outwith the limits of your competence as a General Practitioner with a special interest in gender dysphoria.
Found not proved

Patient B

3. Following an initial consultation with Patient B on or about ~~11~~ 10 August 2016, you failed to provide good clinical care in that you did not:
Amended under Rule 17(6)

a. obtain an adequate medical history for Patient B, in that you failed to elicit information about:

i. general development history;
Found not proved

ii. age of onset of puberty and subsequent pubertal development;
Found not proved

iii. physical history;

Found not proved

iv. mental health history;
Found not proved

v. medication use;
Found not proved

vi. smoking, alcohol and substance use;
Found proved in respect of smoking only

vii. forensic history;
Found proved

b. arrange for Patient B to be **adequately** examined prior to prescribing testosterone treatment, including:
Amended under Rule 17(6)

i. a physical examination to determine:

1. blood pressure; **Found not proved**

2. weight development; **Found not proved**

ii. a psychological assessment to:

1. confirm a diagnosis of gender dysphoria;
Found not proved

2. consider alternative diagnoses;
Found not proved

3. determine Patient B's mental health needs;
Found proved

c. liaise with those who had previously provided care with regard to Patient B's mental health needs, including:

i. the Tavistock and Portman NHS Foundation Trust Gender Identity Development clinic ('the Tavistock');
Found not proved

ii. Patient B's private therapist;
Found not proved

iii. the Child and Adolescent Mental Health Services team;
Found not proved

d. conduct an adequate assessment of Patient B prior to testosterone treatment, including eliciting details of:

i. height; **Found proved**

ii. weight; **Found proved**

iii. blood pressure; **Found proved**

iv. Tanner staging of Patient B's pubertal development, including stages of:

1. pubic hair growth; **Found not proved**

2. breast development; **Found not proved**

e. obtain informed consent in that you failed to ascertain:

i. how Patient B had reached the decision to agree to his treatment plan; **Found not proved**

ii. whether Patient B understood the long term risks of the treatment proposed; **Found not proved**

f. adequately assess Patient B's capacity to consent to treatment;
Found not proved

g. in the alternative to Paragraph 3f, record any assessment of Patient B's capacity to consent;
Found proved

h. provide adequate follow-up care to Patient B after initiating treatment in that you failed to arrange review consultations;
Found proved

i. provide the correct change to Patient B's prescription when he reported continued menstruation in that you:

i. failed to prescribe a step-up dosage of testosterone;
Found not proved

ii. inappropriately prescribed Gonadotropin-releasing Hormones ~~('GnHRa')~~ <u>(GnRHa)</u>; **Amended under Rule 17(6)**
Found not proved

j. engage in and / or with an adequately trained and specialist multidisciplinary and interdisciplinary team, in that you did not seek input before and during treatment from a:

i. paediatric endocrinologist; **Found not proved**

ii. mental health practitioner. **Found not proved**

4. In treating Patient B as set out at paragraph 3 above, you:

a. failed to adhere to the following professional guidelines:

i. Endocrine Society Professional Guidelines (2009);
Found not proved

ii. World Professional Association for Transgender Health Standards of Care (7th Edition);
Found not proved

b. knew or ought to have known you were acting outwith the limits of your competence as a General Practitioner with a special interest in gender dysphoria.
Found not proved

Patient C

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

a. did not arrange for Patient C to be **<u>adequately</u>** examined prior to prescribing ~~testosterone and GnHRA~~ <u>GnRHa</u> treatment, including:
Amended under Rule 17(6)

i. a physical examination to determine:

1. bone health; **Found not proved**

2. height; **Found proved**

3. weight; **Found proved**

4. blood pressure; **Found not proved**

5. Tanner staging of Patient C's pubertal development, including stages of:

i. pubic hair growth; **Found not proved**

ii. breast development; **Found not proved**

ii. full psychological pre-diagnostic input to:

1. clarify diagnoses; **Found proved**

2. explore additional factors, including Attention Deficit Hyperactivity Disorder; **Found proved**

b. did not record the details of any assessment as set out at paragraph 5a above;
Found proved insofar as it related to paragraph 5(a)(i)(5)

c. prescribed ~~GnRHA~~ <u>GnRHa</u> to Patient C without:
Amended under Rule 17(6)

i. the adequate training, qualifications or experience in the field of paediatric endocrinology;
Found not proved

ii. working as part of a specialist multidisciplinary team in gender care for children and adolescents;
Found not proved

d. advised Patient C as to the risks of ~~GnRHA~~ <u>GnRHa</u> before commencing treatment without: **Amended under Rule 17(6)**

i. the adequate training, qualifications or experience in the field of paediatric endocrinology;
Found not proved

ii. working as part of a specialist multidisciplinary team in gender care for children and adolescents;
Found not proved

iii. discussing the risks to Patient C's fertility;
Found proved

e. did not assess Patient C's capacity to consent to treatment;
Found not proved

f. in the alternative to Paragraph 5e, did not record any assessment of Patient C's capacity to consent;
Found proved

g. did not record Patient C's reasoning ability and competence with regards to his treatment;
Found proved

h. did not provide adequate follow-up care to Patient C after initiating ~~GnRHA~~ GnRHa treatment in that you:
Amended under Rule 17(6)

i. failed to monitor Patient C's physical development;
Found not proved

ii. did not review Patient C's treatment plan with a multi-disciplinary team when Patient C started his menstruation cycle, including considering the prescribing of progestins;
Found not proved

i. did not maintain an adequate record of Patient C's care in that entries in records were:

i. infrequent; **Found proved**

ii. made by administrative staff; **Found not proved**

iii. unclear as to who had made them; **Found proved**

iv. made using email print-offs rather than an electronic record system; **Found not proved**

j. did not engage in and/or or with an adequately trained and specialist multidisciplinary and interdisciplinary team, in that you did not seek:

i. any input before and during treatment from a paediatric endocrinologist;
Found not proved

ii. psychological input following an initial assessment;
Found not proved

iii. input from services already engaged in Patient C's care at the Tavistock.
Found not proved

6. In treating Patient C as set out at paragraph 5 above, you:

a. failed to adhere to the following professional guidelines:

i. Endocrine Society Professional Guidelines (2009);
Found not proved

ii. World Professional Association for Transgender Health Standards of Care (7th Edition);
Found not proved

b. knew or ought to have known you were acting outwith the limits of your competence as a General Practitioner with a special interest in gender dysphoria.
Found not proved

CQC – Dr Matt Limited

7. On the dates set out in Schedule 1, you inappropriately prescribed an increased dose to Patient D through a pharmacy website without any evidence that the change in dose was correct.
Found not proved

8. On 26 August 2016, you dealt with Patient E's medication request made through a pharmacy website and you:

a. failed to:

~~i. adequately assess Patient E in that you did not seek further details of~~:

~~1. their symptoms~~;
Withdrawn following a successful Rule 17(2)(g) application

~~2. why they thought they had a STI~~;
Withdrawn following a successful Rule 17(2)(g) application

ii. refer Patient E to a Genito Urinary Medicine clinic for further investigations and/or tests;
Found not proved

iii. provide follow up advice in that you did not advise Patient E to attend at a GUM clinic in the event that they were suffering from a STI;
Found not proved

~~iv. record your:~~

~~1. assessment of Patient E as set out at paragraph 8ai above;~~ **Withdrawn following a successful Rule 17(2)(g) application**

~~2. referral of Patient E to a GUM as set out at paragraph 8aii above;~~ **Withdrawn following a successful Rule 17(2)(g) application**

~~3. follow up advice to Patient E as set out at paragraph 8aiii above;~~ **Withdrawn following a successful Rule 17(2)(g) application**

b. prescribed 'Doxycycline 100mg 2 daily for 2 weeks' to Patient E which was not clinically indicated because you did not:

~~i. adequately assess Patient E as set out at paragraph 8ai above;~~
Withdrawn following a successful Rule 17(2)(g) application

ii. refer Patient E for further investigations as set out at paragraph 8aii above.
Found not proved

9. On 10 January 2017, during an ~~un~~announced CQC inspection of Dr Matt Limited, you were the Safeguarding Lead and you: **Amended by the Tribunal**

a. were unaware of the safeguarding policy;
Found proved

b. had never seen a copy of the safeguarding policy.
Found proved

Royal College of General Practitioners ("RCGP")

10. On 9 May 2017 you submitted to the Interim Orders Tribunal ('the IOT') a:

a. signed witness statement in which you stated that you had been a member of the RCGP since 1996; **Admitted and found proved**

b. copy of your Curriculum Vitae which stated that you had been a member of the RCGP since 1996.
Found not proved

11. You have never been a member of the RCGP.
Found proved

12. You submitted information to the IOT which was untrue.
Found proved

13. You knew that the information provided in the documents referred to at paragraph 10 above was untrue.
Found not proved

14. Your actions as described as paragraphs 10 - 12 were dishonest by reason of paragraph 13.
Found not proved

Work Details Form

~~15. You completed and signed a Work Details Form ('the WDF') on 5 March 2017 in which you failed to declare that you were sub-contracted to provide medical services to Frosts Pharmacy until 24 May 2017.~~
Withdrawn following a successful Rule 17(2)(g) application

~~16. When you completed the WDF, you knew you were sub-contracted to provide medical services to Frosts Pharmacy until 24 May 2017.~~
Withdrawn following a successful Rule 17(2)(g) application

~~17. Your conduct as described at paragraph 15 was dishonest by reason of paragraph 16.~~
Withdrawn following a successful Rule 17(2)(g) application

Suspension from the Medical Performers List

18. On 25 April 2017 you were suspended from the Medical Performers List and you failed to notify Frosts Pharmacy of this.
Found proved

19. You knew that you were required to inform Frosts Pharmacy of your suspension from the Medical Performers List.
Found not proved

20. Your conduct as described at paragraph 18 was dishonest by reason of paragraph 19.

Found not proved

Aneurin Bevan University Health Board

21. In July 2017 a review was initiated by Aneurin Bevan University Health Board ('the Health Board') into your on-line prescribing practices ('the Review') and you:

a. repeatedly frustrated the Health Board's attempts to carry out the Review in that you:

i. consistently challenged the Review where there was no basis to do so, in that you questioned the:

1. terms of reference; **Found not proved**

2. competence of the investigators; **Found not proved**

3. training of the investigators; **Found not proved**

4. the proposed CQC methodology; **Found not proved**

ii. continued to challenge the Review as set out at paragraph 21ai above when investigators visited your house on 5 October 2017, preventing any progress to the Review;
Found not proved

~~b. failed to advise the Health Board throughout the period of the Review of open GMC investigations against you.~~
Withdrawn following a successful Rule 17(2)(g) application

22. During the Review, you knew that you were:

a. the subject of open GMC investigations;
Found proved

~~b. required to inform the Health Board of ongoing GMC investigations.~~
Withdrawn following a successful Rule 17(2)(g) application

~~23. Your conduct asset out at paragraph 21b was dishonest by reason of paragraph 22.~~
Withdrawn following a successful Rule 17(2)(g) application

Gender GP

24. Alongside Dr SS, you operate and control the company known as Gender GP, through which you provided care and treatment.
Found proved

~~25. As the principal provider of the Gender GP website, offering hormonal treatment to children, you failed to appropriately reference:~~

~~a. the input of any accredited paediatrician/paediatric specialist;~~
Withdrawn following a successful Rule 17(2)(g) application

~~b. your safeguarding policy.~~
Withdrawn following a successful Rule 17(2)(g) application

~~26. On the governance page of the Gender GP website it states that 'all medical advice and prescriptions are provided by doctors working outside of the UK'.~~
Withdrawn following a successful Rule 17(2)(g) application

~~27. The operating method of Gender GP as set out at paragraph 26 above is motivated by efforts to avoid the regulatory framework of the United Kingdom, including regulation by the:~~

~~a. CQC;~~ Withdrawn following a successful Rule 17(2)(g) application

~~b. HIW;~~ Withdrawn following a successful Rule 17(2)(g) application

~~c. GMC.~~ Withdrawn following a successful Rule 17(2)(g) application

Conviction

28. On 5 October 2018 at the Mid Wales (Merthyr Tydfil) Magistrates' Court you were convicted, contrary to Section 11(1) of the Care Standards Act 2000, in that you did:

a. carry on or manage an independent medical agency, namely Online GP Services Limited, without being registered under Part 11 of the Care Standards Act 2000; Admitted and found proved

b. as a director of Online GP Services Limited, consent to that company carrying on or managing an independent medical agency, namely Online GP Services, without it being registered under Part 11 of the Care Standards Act, thereby committing an offence contrary to section 30(2) of the Care Standards Act 2000.
Admitted and found proved

29. On 3 December 2018 you were sentenced to pay a fine in the sum of £12,000.00.
Admitted and found proved

And that by reason of the matters set out above your fitness to practise is impaired because of your:

a. misconduct as set out at paragraphs 1 – 27; **To be determined**

b. conviction as set out at paragraphs 28 - 29. **To be determined**

Legally Qualified Chair's Legal Advice on Facts

Legal Advice in respect of the facts

Burden of Proof

1. The burden of proving each paragraph of the allegation rests on the GMC. Dr Webberley is not obliged to prove or disprove anything.

2. Each paragraph must be considered separately.

Standard of Proof

3. The standard of proof is the balance of probabilities. That means that a fact will be proved if the evidence establishes, in the view of the Tribunal, that it is more likely than not to be true, or to have happened.

4. That standard of proof takes into account the probabilities that (in this case) Dr Webberley acted in the particular way alleged in any of the charges. A probability is the extent to which something is likely to be the case. If an event is inherently improbable, it may take better evidence (or more cogent evidence) to persuade the judge that it has happened than would be required if the event were mere commonplace. That does not mean that there is a higher standard of proof. In re S-B (Children) (Care Proceedings: Standard of Proof) [2010] 1 AC 678

Interpretation

Failed

5. This word imports the allegation that Dr Webberley was *under a duty to do something which it is alleged she did not do*.

6. When the Tribunal comes to consider such an allegation, it will certainly have to consider whether she was under the duty alleged, as well as whether she did not do it

and if so, without good reason. This may be a simple issue. But there are instances where the defence challenge whether she was under the duty.

7. Whether Dr Webberley was under a duty to do or not to do something may depend on whether she was acting in accordance with the practice adopted by a recognised body of medical opinion. In the context of the tort of negligence, there is some case law which assists on this issue. It is of course important to remember that the Tribunal is not trying a case of negligence – there is no element of loss or damage in regulatory proceedings. This is not to introduce a negligence test in these proceedings. It is to reflect the point that there may be more than one recognised body of opinion in this field of medicine. Whether or not there is will entirely depend on the Tribunal's assessment of the evidence it has heard. The cases are:

Bolam v Friern Hospital Management Committee [1957] 2 All ER 118

That established the Bolam Test as follows:

Accordingly, it is sufficient if a doctor, surgeon, midwife or nurse follows a practice adopted by a recognised body of medical opinion. If there is such a body of medical opinion and it is followed, then the medical practitioner will not be liable for any adverse outcome despite the existence of another medical practice that would have adopted a different course which could or would have produced a better outcome.

Maynard v West Midlands Regional Health Authority [1985] 1 All ER 635

Lord Scarman stated

"It is not enough to show that there is a body of competent professional opinion which considers that theirs was a wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances. …

Differences of opinion and practice exist, and will always exist, in the medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgment. A court may prefer one body of opinion to the other, but that is no basis for a conclusion of negligence.

… I have to say that a judge's 'preference' for one body of distinguished professional opinion to another also professionally distinguished is not sufficient to establish negligence in a practitioner whose actions have received the seal of approval of those whose opinions, truthfully expressed, honestly held, were not preferred. If this was the real reason for the judge's finding, he erred in law even though elsewhere in his judgment he stated the law correctly. *For in the realm of diagnosis and treatment negligence is not established by preferring one respectable body of professional*

opinion to another. Failure to exercise the ordinary skill of a doctor (in the appropriate speciality, if he be a specialist) is necessary”

Bolitho (Administratrix of the Estate of Patrick Nigel Bolitho (deceased)) v City and Hackney Health Authority [1997] 4 All ER 771

This *case* established that a doctor could be liable for negligence in respect of diagnosis and treatment despite a body of professional opinion sanctioning his conduct where it had not been demonstrated to the judge's satisfaction that the body of opinion relied on was *reasonable or responsible*. In the vast majority of cases the fact that distinguished experts in the field were of a particular opinion would demonstrate the reasonableness of that opinion. However, in a rare case, *if it could be demonstrated that the professional opinion was not capable of withstanding logical analysis*, the judge would be entitled to hold that the body of opinion was not reasonable or responsible.

8. So, in summary:

In an action involving clinical judgment there is a two-step procedure to determine the question of alleged medical negligence:
(a) whether the medical practitioner acted in accordance with a practice accepted as proper for an ordinarily competent medical practitioner by a responsible body of medical opinion; and
(b) if “yes”, whether the practice survives *Bolitho* judicial scrutiny as being “responsible” or “logical”.

9. That case law does not detract from standard of care which the Tribunal should apply in this case. The standard is that of the reasonably competent general practitioner with a special interest in gender care and sexual health.

Adequate or adequately

10. There is a value judgment which the Tribunal will have to make, based on all the evidence, where this word is found in the allegations.

Expert Evidence

11. Expert witnesses give evidence and opinions to assist on matters of a specialist kind which are not of common knowledge. However, as with any other witness, it is the Tribunal’s task to weigh up the evidence of the expert(s), which includes any evidence of opinion, and to decide what evidence they accept and what they do not.

12. The Tribunal should take into account, as appropriate, the qualifications/practical experience/methodology/source material/quality of analysis/whether or not based upon a statistical analysis/objectivity of the experts.

13. Any factors capable of undermining the reliability of the expert opinion or detracting from his/her credibility or impartiality may assist the Tribunal in evaluating and assessing the weight of the expert evidence.

14. Additional factors that may be relevant

i) the extent to which any material upon which the expert's opinion is based has been reviewed by others with relevant expertise such as peer reviewed publications, and the views of those others on that material;
ii) the extent to which the opinion is based on material which is outside the expert's field of expertise;
(iii) the completeness of the information available to the expert, and whether the expert took account of all relevant information in arriving at the opinion, which includes information as to the context of any facts to which the opinion relates;
(iv) if there is a range of expert opinion on the matter in question, where in that range the expert's own opinion lies and whether the expert's preference has been properly explained;
(v) whether the expert's methods followed established practice in the field and, if they did not, whether the reason for the divergence has been properly explained.

Hearsay

15. The GMC and Dr Webberley rely on hearsay evidence. That is to say documentary evidence where the witness has not been called to give evidence. Whilst the evidence has been properly admitted under the Fitness to Practise Rules, the Tribunal should consider:

(a) There has been no opportunity to see the demeanour of the person who made the statement.
(b) The statement admitted as hearsay was not made on oath.
(c) There has been no opportunity to see the witness's account tested under cross-examination, for example as to accuracy, truthfulness, ambiguity or misperception, and how the witness would have responded to this process
Ultimately, the weight of this evidence, as with all the other evidence, is a matter for the Tribunal.

Loss of or missing documents

16. Lost or missing material conceivably could have put Dr Webberley at a serious disadvantage, in that documents and other materials which she would have wished to

deploy are not before the Tribunal. The Tribunal should take this possible prejudice to the doctor into account when considering whether the GMC has been able to prove the relevant paragraph.

Capacity and Consent

17. General principles:

Like adults, young people (aged 16 or 17) are presumed to have sufficient capacity to decide on their own medical treatment, unless there's significant evidence to suggest otherwise.

Children under the age of 16 can consent to their own treatment if they're believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment. This is known as being Gillick competent.

A person lacks capacity if their mind is impaired or disturbed in some way, which means they're unable to make a decision at that time.

The person must be given all of the information about what the treatment involves, including the benefits and risks (*and side effects*), whether there are reasonable alternative treatments, and what will happen if treatment does not go ahead.

What is consent?

18. In C6: GMC Booklet: Consent Patients and Doctors making decisions together 2008 paragraph 5

If patients have capacity to make decisions for themselves, a basic model applies:
a The doctor and patient make an assessment of the patient's condition, taking into account the patient's medical history, views, experience and knowledge.
b The doctor uses specialist knowledge and experience and clinical judgement, and the patient's views and understanding of their condition, to identify which investigations or treatments are likely to result in overall benefit for the patient. *The doctor explains the options to the patient, setting out the potential benefits, risks, burdens and side effects of each option, including the option to have no treatment.* The doctor may recommend a particular option which they believe to be best for the patient, but they must not put pressure on the patient to accept their advice.

19. What is capacity?

In Gillick v.West Norfolk and Wisbech AHA [1986] AC 112 Lord Scarman observed at page 184B,

"nor has our law ever treated the child as other than a person with capabilities and rights recognised by law"

and continued at page 189C-E:

"When applying these conclusions to contraceptive advice and treatment it has to be borne in mind that there is much that has to be understood by a girl under the age of 16 if she is to have legal capacity to consent to such treatment. It is not enough that she should understand the nature of the advice which is being given: she must also have a sufficient maturity to understand what is involved. There are moral and family questions, especially her relationship with her parents; long-term problems associated with the emotional impact of pregnancy and its termination; and there are the risks to health of sexual intercourse at her age, risks which contraception may diminish but cannot eliminate. It follows that a doctor will have to satisfy himself that she is able to appraise these factors before he can safely proceed upon the basis that she has at law capacity to consent to contraceptive treatment. and it further follows that ordinarily the proper course will be for him, as the guidance lays down, first to seek to persuade the girl to bring her parents into consultation, and if she refuses, not to prescribe contraceptive treatment unless he is satisfied that her circumstances are such that he ought to proceed without parental knowledge and consent."

20. When considering capacity, there is also the issue as to whether in fact the patient retains the necessary capacity in the context of his / her gender dysphoria and / or other comorbid conditions.

Who must consent?

21. Bell v. The Tavistock and Portman NHS Foundation Trust & Ors: [2021] EWCA Civ 1363:
In para 83 of the Court of Appeal's judgment, it was held:

The policy and practice under consideration in this case requires the informed consent of both child and parents before Tavistock refers to the Trusts, again before either Trust prescribes puberty blockers and once more before prescription of cross-sex hormones.

22. That is the regime under the NHS Specification which set up the Portman and Tavistock clinic. But Dr Webberley's prescribing was not under that NHS Specification. She was working in a private capacity. Lord Scarman considered parental rights in Gillick:

Gillick v.West Norfolk and Wisbech AHA [1986] AC 112
"I would hold that as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and

when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give consent valid in law."

As Lord Scarman stated, that was a case about when parental rights to determine whether a child who had capacity will have medical treatment terminates. It is not a case about whether a parent of a child who lacks capacity or who is in agreement with the treatment proposed may consent to that treatment on the child's behalf.

23. Gillick was considered in

AB and CD v Tavistock and UCL [2021] EWHC 741 (Fam)
This was a case where the court was considering whether the parent could consent to the ongoing treatment of puberty blockers for a child who, although competent, had not given (further) consent because of lack of time or opportunity. The situation was consequential on the decision of the Divisional Court in Bell v [2020] EWHC 3274 (Admin) as UCL ceased recommending prescribing for its Tavistock clients until such time as the case was considered on appeal.

68. However, in the present case, the parent and the child are in agreement. Therefore, the issue here is whether the parents' ability to consent disappears once the child achieves Gillick competence in respect of the specific decision even where both the parents and child agree. In my view it does not. The parents retain parental responsibility in law and the rights and duties that go with that. One of those duties is to make a decision as to consent in medical treatment cases where the child cannot do so ***. The parent cannot use that right to "trump" the child's decision, so much follows from Gillick, but if the child fails to make a decision then the parent's ability to do so continues.*** *At the heart of the issue is that the parents' "right" to consent is always for the purpose of ensuring the child's best interests. If the child does not, for whatever reason, make the relevant decision then the parents continue to have the responsibility (and thus the right) to give valid consent.*

69. This might arise if the child is unable to make the decision, for example is unconscious. However, it could also arise if the child declines to make the decision, perhaps because although Gillick competent she finds the whole situation too overwhelming and would rather her parents make the decision on her behalf. In the present case, in the light of the decision in Bell, and the particular issues around Gillick competence explained in that judgment, it has not been possible to ascertain whether the child is competent. In this case, there are two options. ***If the child is Gillick competent, she has not objected to her parent giving consent on her behalf. As such, a doctor can rely on the consent given by her parents. Alternatively, the child is not Gillick competent. In that case, her parents can consent on her behalf.*** *It is not necessary for me or a doctor to investigate which route applies to give the parents authority to give consent. Therefore, in my view, whether or not XY is Gillick competent*

to make the decision about PBs, her parents retain the parental right to consent to that treatment.

24. The other question which AB and CD v Tavistock and UCL [2021] EWHC 741 (Fam) decided was as follows:

    Is there a special category of medical treatment requiring court authorisation, and do puberty blockers fall within it?

    The Court determined that there was not.

25. It follows therefore that a parent can give consent to hormone treatment if a Gillick competent has not given consent but has not objected or if the child is not Gillick competent.

Dr Webberley's Defence to her alleged failure to inform Frosts Pharmacy of her suspension from the Medical Performers List

26. I understand her case to be twofold:

    a. she was no longer under an obligation to do so as she had ceased prescribing for Frosts PL before her suspension from the MPL.
    b. she did not know that she was obliged to inform Frosts although this is governed by GMP:

Dishonesty

27. There are 2 paragraphs of the Allegation which allege dishonesty against Dr Webberley;

    a. Paragraph 14 concerning matters she (allegedly) submitted to the IOT about being a member of the RCGP (paragraph 10);

    b. Paragraph 20 concerning her (alleged) failure to inform Frosts Pharmacy that she had been suspended from the Medical Performers List (paragraph 18).

28. Paragraphs 14 and 20 respectively refer to the knowledge which the GMC allege Dr Webberley had at the material time and upon which the GMC relies to draw the inference of dishonesty.

    a. For paragraph 14, it is paragraph 13: You knew that the information provided in the documents submitted to the IOT referred to at paragraph 10 was untrue;

b. For paragraph 20, it is paragraph 19: You knew that you were required to inform Frosts Pharmacy of your suspension from the Medical Performers List.

29. By the time the Tribunal will be considering dishonesty in paragraph 14 or 20, it will already have decided whether the information submitted to the IOT in paragraph 10 was untrue and whether Dr Webberley knew she was required to inform Frosts of her suspension as alleged in paragraph 18. If the Tribunal find that the information was not untrue or that she was not required to inform Frosts of her suspension, the respective allegation of dishonesty does not proceed.

30. With regard to dishonesty, pursuant to the case of R v. *Barton & Booth [2020] EWCA Crim 575*

Where it is alleged that a doctor is dishonest, it is for the GMC to prove that dishonesty. It is not for the doctor to prove that he or she was honest. The burden of proof remains throughout the hearing on the GMC.
When considering the question of dishonesty, the Tribunal must firstly, ascertain the doctor's actual state of mind as to knowledge or belief as to the facts; that is, ascertain what the doctor genuinely knew or believed the facts to be. When considering the belief as to the facts, the reasonableness or unreasonableness of his or her belief is a factor that is relevant to the issue of whether the person genuinely held the belief. However, it is not an additional requirement that the belief must be reasonable. The question is whether the belief was genuinely held.
Secondly, having determined the doctor's state of knowledge or belief, the Tribunal should go on to determine whether the doctor's conduct, as it has found it to be, was honest or dishonest by the standards of ordinary decent people.

31. The Tribunal has been provided with passages from the Court of Appeal's judgment in Barton & Booth. It should also take into account the decision of the court in Fish v. GMC [2012} EWHC 1269 (Admin) where Foskett J. observed:

I do not think that I state anything novel or controversial by saying that [dishonesty] is an allegation that (a) should not be made without good reason (b) when it is made it should be clearly particularised so that the person against whom it is made knows how the allegation is put and (c) that when a hearing takes place at which the allegation is tested, the person against whom it is made should have the allegation fairly and squarely put to him so that he can seek to answer it.

32. Directions

a. Good Character Direction:

Dr Webberley appears before the Tribunal as someone of good character. By that expression I mean that she has not been convicted of any offence of

dishonesty. That is an important matter. It is something which the Tribunal should take into account in 2 ways.
First, the doctor has given evidence. Her good character is a positive feature which the Tribunal should take into account in her favour when considering whether it accepts what Dr Webberley told us. Secondly, the fact that she has not offended in the past may make it less likely that she acted as the GMC alleges in this case. What importance the Tribunal attaches to this aspect of good character and the extent to which it assists on the facts of this particular case are for the Tribunal to decide. In making that assessment the Tribunal may take account of everything it has heard about Dr Webberley.

In the event that the Tribunal find proved that she behaved dishonestly on the earlier of those two occasions, namely when submitting information to the IOT on 9 May 2017, she will lose the advantage of this direction in respect of the 2nd allegation of dishonesty in respect of her alleged failure to inform Frosts Pharmacy of her suspension from the Medical Performers List.

b. If the Tribunal find Dr Webberley to have been dishonest in respect of paragraph 14 of the Allegation, that will be something which the Tribunal can take into account when considering paragraph 20 of the allegation. Again however, it is not determinative.

Determination on Impairment - 28/06/2022

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

The Evidence

2. The Tribunal has taken into account all the evidence received during the facts stage of the hearing. This included oral evidence from Dr Webberley and a bundle of documents provided by her, including her reflective statement, dated 4 June 2022, certificates of courses she had completed as part of her Continuing Professional Development (CPD), to keep her medical knowledge and skills up to date, and the steps she has taken to address the concerns identified in this case.

3. In her oral evidence, Dr Webberley was asked a number of questions concerning proposed changes to the WPATH guideline, a draft copy of which was placed before the Tribunal, labelled exhibit C63 'GMC Stage 2 bundle - WPATH 8 chapters'. She told the Tribunal that in general, she supported the proposed changes to the guidelines, stating that they *'would be a helpful update'* and they are *'an excellent framework to work within'*. She added that her comment on her podcast that the assessment appeared to concern whether

an individual was 'trans enough' should not be taken out of context and did not specifically relate to the chapters presented to her by the GMC. It related to the assessment criteria in the USA, which was different to that in the UK. Dr Webberley explained that people with transgender issues go to enormous lengths before they are provided with medical intervention. She stated that *'the opposite of not giving treatment too soon is giving treatment too late'.* Dr Webberley added that she agreed with the WPATH proposed revisions to some aspects of the Guidelines such as in relation to adolescents. She said the assessment process was very important to ascertain the merits of medical intervention, the risks, and to understand individuals social and family structure, etc, and was focussed on helping the individual. Dr Webberley said that she had not, in light of the Tribunal's findings on the facts, and the proposed changes to the WPATH Guidelines, identified any gaps in her training. She added that as a GP, she already had extensive knowledge and skills to be able to carry out and/or make appropriate assessments of patients presenting symptoms. Dr Webberley added that she was keen to further develop her knowledge and expertise in this area of medicine.

4. Dr Webberley directed the Tribunal to her reflective statement in which she set out her case following the Tribunal's findings on facts, how she had or would address the concerns identified in this case, and how she would change her clinical practice, and her learning from CPD activity which she had undertaken since these events. She said that this was an emerging and evolving area of healthcare and her service was continually being refined and improved to provide the standard of care considered appropriate in each patient's case. She added that the hub and spoke arrangement she had put in place to network and work with specialists had expanded further, even whilst she was not practising.

5. In relation to history taking, Dr Webberley said that whether an individual had smoked, or taken drugs or alcohol, was not a reason to deny medical treatment, stating that health promotion advice formed part of the ongoing care and treatment plan for the patient, and was better undertaken at a time when the impact of such would be maximal. In this regard, Dr Webberley told the Tribunal that she had taken account of the recently published guidance from Australia and New Zealand, both of which were published in 2018.

6. In relation to psychological assessment, Dr Webberley said that this was part of an ongoing process. She said that, had she continued to provide care and treatment to Patient A, B and C, she would have considered this in due course. Dr Webberley said that many patients become disillusioned by numerous psychiatric assessments to determine whether they are gender dysphoric. She said that doctors can only assist a patient to make the best decision for themselves, and that patients themselves are best placed to decide whether medical intervention, such as psychiatric assessments, would assist them.

7. Dr Webberley told the Tribunal that she had attended a two-day remote workshop specific to the care of children and adolescents, at which there was a large representation of psychologists and counsellors. She said it was interesting to see how the different specialties came together to provide the best care to transgender patients. Dr Webberley said that the WPATH guidance was not a checklist to be *'ticked off'*, and that it was important that the

circumstances in each case was considered in determining the appropriate care and treatment plan. Dr Webberley said that she always aimed to get the best out of her patients by providing the appropriate treatment, adding that it was not always helpful to patients with gender identity issues to be subjected to medical or other processes which questioned their gender identity.

8. Dr Webberley told the Tribunal, in relation to Patient C, that whilst she had missed the opportunity to discuss the issue of fertility at the initial consultation with Patient C and his mother, she did so as soon she had realised. She submitted she did discuss it with Patient C's mother later, adding that the consultation is an ongoing process because lots of questions could be raised before, during and after treatment was started. Dr Webberley stated: *'so fertility is incredibly important and has to be appropriate – for patient to understand what it means for future of fertility.'*

9. Dr Webberley said, in relation to forensic history, that her understanding was that this related to physical or sexual abuse, and the evaluation of patients who had committed crimes whilst suffering from mental health. She said that in her role as a GP or a sexual health doctor, she had never incorporated forensic history as part of her history taking. Dr Webberley acknowledged that this was referred to in the 2019 NHS Service Specifications for Adults, but stated that in her experience, questioning Patient A about his forensic history would not have assisted her in determining the appropriate treatment plan. Dr Webberley reminded the Tribunal of Patient A's evidence that he had a negative experience of the assessment process conducted by GIDS. However, she added that it was an area she was keen to explore further with her clinical colleagues.

10. Relating to 'Examination', Dr Webberley told the Tribunal that whilst she asserted at stage 1 of the proceedings that treatment with blockers or hormones would not be affected by blood pressure, she said that she had further reflected on this, in terms of the need for blood pressure monitoring before and during treatment. Dr Webberley drew the Tribunal's attention to the evidence of the experts, as well as the relevant guidelines, stating that she would ensure that in future all patients have a baseline blood pressure reading, and also would consider the risk of hypertension in all patients she treated.

11. Referring to 'Height' and 'Weight', Dr Webberley stated that whilst the guidance was not specific on this, she acknowledged that it was important to ensure that adolescents who are having their puberty induced and maintained medically are growing at the same pace as their cisgender counterparts. Dr Webberley further acknowledged the importance of plotting height and weight on the patient's growth charts and to monitor growth according to centiles. She said that in her future practice she would give due consideration to the length of time between any baseline measurements and the commencement of treatment.

12. Dr Webberley went on to acknowledge, in relation to fertility, that patients who start puberty suppression more often than not go on to gender affirming hormones which could affect fertility in the long run. She recognised she had not adequately discussed this with Patient C at the initial consultation, stating that this was a continual process. Dr Webberley

added that fertility preservation in patients that are assigned female at birth can take place while they were on treatment. Dr Webberley said that fertility was an important consideration and referred the Tribunal to her email to Patient C's mother as evidence of her discussing it with Patient C and his mother. In support of this, Dr Webberley also referred the Tribunal to CPD she had undertaken to further improve her knowledge in this regard.

13. In respect of follow up care, Dr Webberley said that although she relied on her patients to contact her, for example at the end of their prescribed treatment period, she realised this did not allow for all eventualities as happened in the case of Patient A. Dr Webberley said that she would remind patients when she needed to review their care, with a calendar reminder set to ensure that took place.

14. Relating to record keeping, Dr Webberley acknowledged that whilst it was very useful to have email correspondence within patients' records, as it gave a clear written record of information gathered and shared, there should be a summary of each encounter with the patient as to decisions made and actions taken, to assist any clinicians treating the patient in the future. Dr Webberley went on to summarise the benefits of electronic health record systems that were now available.

15. Dr Webberley told the Tribunal, in respect of recording capacity to consent, that she had previously assessed patients' capacity to consent, for example, in relation to contraception and infection services and, on occasions, adolescents seeking termination of pregnancy. Dr Webberley acknowledged that assessing an adolescent's competence to consent, particularly where their parent is not involved, was essential as decisions made can have lifelong implications for the individual. She said that she would in future formally record her findings of an individual's capacity to make decisions and understand treatment options, and would incorporate this into her record keeping. Dr Webberley went on to describe her learning from the online Mental Capacity Act training she undertook on 3 May 2022, and from her attendance at the Documentation and Record Keeping course, level 2, also on the same date.

16. In relation to information sharing with colleagues, Dr Webberley stated that she recognised her duty to ensure that all parties involved in the care of a patient are kept up to date as appropriate, adding she would always take steps to encourage good communication, and to record carefully reasons for not doing so. She referred to relevant guidance on prescribing and to Good Medical Practice ('GMP') on maintaining confidentiality. Dr Webberley said she was aware of the active steps taken by GIDS to withdraw care and treatment to patients who had sought treatment from her, as well as clinicians liaising with GIDS upon receiving correspondence from her in relation to care and treatment options for a patient. She went on to say that often patients who initially refused to give permission for their information to be shared would later change their mind and give permission. Dr Webberley challenged Dr S's personal view that patients who withhold their consent to share their information should be refused the care and treatment they need. Dr Webberley stated that if a patient is being prescribed medication that may cause a serious reaction on its own, or a serious interaction if they were to be prescribed another medication, then it is really

important that their doctor is informed immediately, and it can be noted on their records. However, if the treatment has no surprising ongoing risks, then there is more time to consider information sharing when the patient feels more confident. Dr Webberley added, however, that she would give very careful consideration to sharing information in future cases.

17. Dr Webberley accepted the Tribunal's findings on the allegation concerning the Dr Matt Limited safeguarding policy stating that she should have ensured that there was a formal written policy in place.

18. Referring to the matters relating to her conviction, Dr Webberley stated that she was, as a result of this process, more aware of the regulatory requirements for service providers and that she would ensure she researched any requirements affecting her work very carefully in future. She went to explain the reasons why she did not stop providing care to her existing patient, stating that she did not want to leave her patients vulnerable to harm in the absence of her providing continuing care to them. Dr Webberley spoke of the concerns expressed to HIW by charities supporting and representing the interests of trans and gender diverse people if she had withdrawn the care and treatment to her patients. Dr Webberley added that she had stopped providing medical services in May 2017, adding that it was not until May 2018 that she was summoned, by which time she had already taken the necessary action to deal with the safety of her patients and to abide by the Care Standards Act 2000.

19. In relation to GenderGP, Dr Webberley said that she had no connection with the medical side of GenderGP. Dr Webberley explained that she initially intended GenderGP to be a web forum for sharing information. However, it attracted patients seeking help, advice and treatment. Dr Webberley said that as a result she had to improve her medical knowledge and skills in this field of medicine ensuring her skills were fit for purpose.

20. In response to how she would address or had changed her clinical practice, Dr Webberley said that she was unsure, in view of these proceedings, whether she would be able to secure any suitable employment in which she could demonstrate her learning. She added that whenever she explored mentoring with any particular persons, she was always told to await the outcome of these proceedings.

21. Dr Webberley told the Tribunal she did what she could, and considered appropriate, at the time, to help Patients A – C, in terms of conducting assessments, relevant referrals and subsequent treatment. She acknowledged that each circumstance was different, but generally, if there was a good reason to disclose patient information to other treating clinicians, against the patient's wishes, for example where there was a public health concern, that she would do so. Dr Webberley went on to explain the circumstances surrounding the matters raised in respect of the HIW investigation, and to her subsequent conviction, stating that she was convicted for carrying on with her online business. She stated that the District Judge was not interested in why she was continuing to treat patients notwithstanding she was not registered.

22. In concluding her oral evidence, Dr Webberley stated *'There is no doubt at all in my mind that patients and the public should absolutely trust their doctor, and that doctors should follow the law. The impact of having the conviction on myself was huge, it affected many things in my life from my mortgage to my car insurance. I also know that the public were concerned about it because it was heavily reported in the press, but I hope that I have been able to show that at all times I acted with the best interests of my patients at the forefront of my actions. I totally understand that regulations allow for practitioners and services to follow policy and procedure and to be inspected and investigated as necessary. As soon as I became aware that my service might need registration, I tried to register with both CQC and HIW. For several reasons neither were possible. I truly wanted to work with HIW to gain registration, but this was unfortunately not achieved.'*

Submissions

For the GMC

23. Mr Simon Jackson, QC, submitted that Dr Webberley's fitness to practise is impaired. He took the Tribunal through his written submissions on impairment, summarising the key points. He reminded the Tribunal of the two stage test for impairment, which required a consideration of whether Dr Webberley's actions amounted to serious misconduct and then whether her fitness to practise is impaired. He added that it was necessary for the Tribunal to look to the past as well as the present when considering impairment. He reminded the Tribunal of the concerns in this case and referred it to its findings on facts, emphasising that Dr Webberley had failed to provide good clinical care to Patients A, B and C in respect of what was life-changing treatment. Mr Jackson referred the Tribunal to the matters relating to Dr Webberley's online clinical practice, and reminded it of the matters leading to her conviction.

24. In relation to impairment, and acknowledging the passage of time, Mr Jackson submitted that the Tribunal should look at the steps Dr Webberley has taken to address the concerns identified. He added that the Tribunal had a duty to consider the wider picture and all of the other issues, and not just those relating to gender dysphoria. He reminded the Tribunal of the proposed changes to WPATH guidelines, and that Dr Webberley is a member of WPATH. He said it is clear from Dr Webberley's recent communications in respect of the proposed changes to the guidelines, that she has applied a rather narrow approach, and had not taken all necessary steps and actions to ensure appropriate care and treatment to Patients A, B and C. Mr Jackson submitted that even today, almost six years since these events, Dr Webberley does not accept any wrongdoing, and it is only because of the findings of the Tribunal, that she has considered changing her clinical practice. Mr Jackson said that this demonstrated Dr Webberley's lack of insight.

For Dr Webberley

25. Mr Ian Stern QC submitted that Dr Webberley's fitness to practise is not impaired. He took the Tribunal through his written submissions on impairment summarising the key

points. He too reminded the Tribunal of the two-stage process. Mr Stern submitted that the matters found proved at the facts stage did not amount to serious misconduct. He referred the Tribunal to case law he submitted was relevant. Mr Stern referred the Tribunal to the documentation provided by the GMC at this stage of the proceedings, in particular the WPATHSOC8 draft guidelines, stating that these were only draft guidelines, and were in fact no longer available, and there was no evidence that any of the content formed part of the final guidelines. He referred the Tribunal to the text in the document which states: *'WPATH PROPERTY CONFIDENTIAL DRAFT FOR PUBLIC COMMENT NOT FOR DISTRIBUTION'*. Mr Stern said that the GMC had taken an unfair approach on these matters and it was questionable as to how relevant these draft guidelines were and that it would be unfair to Dr Webberley if the Tribunal relied upon these. Mr Stern reminded the Tribunal that the GMC did not in their written submissions make any reference to the WPATHSOC8 draft guidelines and only provided verbal submissions when prompted by the Tribunal.

26. Mr Stern referred the Tribunal to its determination on the facts reminding it that it had found Dr Webberley to be a competent doctor in this area of medicine. He submitted that Dr Webberley acknowledged there were some things she could have done better. Mr Stern highlighted salient points from Dr Webberley's podcast, stating that this demonstrated she was prepared to have an open and honest discussion about this area of medicine and her clinical practice. Further, Mr Stern stated that this showed that despite the GMC proceedings, Dr Webberley did not lose interest in or the ability to tell others what had happened in her case.

27. Mr Stern referred the Tribunal to Dr Webberley's reflective statement highlighting how she will change her clinical practice in the future, together with her learning from the CPD activity she had undertaken.

28. Mr Stern referred to relevant case law. He submitted that individual failures, which in of themselves did not reach the threshold for serious misconduct, could not be amalgamated to reach that threshold of serious misconduct and/or a finding of impairment. Mr Stern went through each allegation found proved by the Tribunal and gave an explanation as to why Dr Webberley acted in the way she did, citing expert evidence where appropriate to support or challenge the expert opinion.

29. Mr Stern concluded by stating that in view of the Tribunal's limited adverse findings relating to Patients A, B and C, the overall outcome was that Dr Webberley saved their lives. He referred the Tribunal to the testimonial evidence and witness evidence who spoke very highly of Dr Webberley. In all the circumstances, Mr Stern submitted that Dr Webberley's fitness to practise is not impaired.

The Relevant Legal Principles

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

31. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct which was serious; and secondly, whether the finding of serious misconduct and/or conviction should lead to a finding of impairment.

32. The Tribunal must determine whether Dr Webberley's fitness to practise is impaired today, taking into account her conduct at the time of the events and any relevant factors since then, such as whether the matters are remediable, have been remedied and any likelihood of repetition. It should also consider whether a finding of impairment is warranted taking into account the wider public interest.

33. Throughout its deliberations, the Tribunal has been mindful of its responsibility to uphold the overarching objective as set out in the Medical Act 1983 (as amended). That objective is the protection of the public and involves the pursuit of the following:

a. to protect, promote and maintain the health, safety and wellbeing of the public
b. to maintain public confidence in the profession
c. to promote and maintain proper professional standards and conduct for members of the profession

The Tribunal's Decision

Misconduct

34. The Tribunal first considered whether the facts found proved are a sufficiently serious departure from the standards of conduct reasonably expected of Dr Webberley, to amount to misconduct. In its deliberations, the Tribunal had regard to the March 2013 edition of GMP, which was the version in place at the material time. It also noted that misconduct is not defined by statute but it has been said to be serious professional misconduct or conduct which a fellow professional would regard as deplorable.

35. The Tribunal had regard to the summary at the beginning of GMP and paragraphs 1, 15, 32, and 65 of GMP. These state:

'Good medical practice describes what it means to be a good doctor.

It says that as a good doctor you will:
•*make the care of your patient your first concern*
•*be competent and keep your professional knowledge and skills up to date…..*
•*establish and maintain good partnerships with your patients ….*

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

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

> *a. adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
>
> *b. promptly provide or arrange suitable advice, investigations or treatment where necessary*
>
> *c. ......*

32 You must give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.

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

Tribunal's determination on misconduct

Paragraph 1(b)(i)1

> 1 Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:
>
> > b Arrange for Patient A to be adequately examined prior to prescribing testosterone treatment, including
> >
> > > (i) a physical examination to determine:
> > >
> > > > 1. blood pressure;

36. Although Dr Webberley had information from the UCLH clinic letter concerning Patient A, this did not disclose any blood pressure readings. In her first witness statement for stage 1, she explained:

'I obtain blood pressure readings in one of three ways, from a verbal account from a recent reading from the patient, from a physical reading, or from a report from another doctor. In the questionnaire on [pages 11-13/C4a], and on the UCLH clinic

letter given to me by Mum [page 83/C4a], the blood pressure was not taken nor provided. Blood pressure was not provided at his UCLH clinic letter or in response to his questionnaire, ….'

37. In fact, blood pressure readings were taken at UCLH on 30 July and 10 September 2015, and 3 March 2016, but Dr Webberley was not informed of them. When she prescribed testosterone for Patient A on 19 April 2016, Dr Webberley knew that UCLH had prescribed GnRHa for Patient A on 10 September 2015. She therefore had reason to believe that he had been assessed by GIDS, and that, as GIDS prescribed and continued to prescribe GnRHa for Patient A, he was a fit and healthy 12 year old. That is a conclusion which she was entitled to draw from these circumstances; it was not entirely based on her impression of him when they met on 22 March 2016.

38. The GMC relied on the expert evidence of Dr S and Dr P. The former cited NHS England's Service Specification 1719 in support of his statement that height, weight and blood pressure were *'essential before recommending treatment with testosterone'*. Service Specification 1719 is for adults. The Tribunal was informed that Dr S had not treated transgender adolescents, and he did not explain why a blood pressure reading was essential. Dr P explained that:

'Arterial hypertension is a rare but serious adverse event especially in transgender boys and therefore blood pressure should have been tested when a patient is on blockers.'

39. However, as mentioned, Dr Webberley would have been entitled to assume that Patient A's blood pressure would have been regularly tested if GIDS continued to prescribe him with GnRHa. In respect of a prescription of testosterone, Dr P also stated in his report:

'Prior to start history and (sic) physical examination to evaluate height, weight, sitting height, blood pressure, Tanner stage and overall health assessment.'

40. Dr P did not explain why a blood pressure examination should take place.

41. The GMC also relies upon:

'Guidance for GPs, other clinicians and health professionals on the care of gender variant

Monitoring suggestions Baseline: initially, record weight, height, blood pressure and urine tests; full blood count; liver and renal function; lipid profile; thyroid-stimulating hormone; prolactin; fasting glucose; luteinising hormone; follicle-stimulating hormone; oestradiol and testosterone; and clotting screen.

Guidelines on the Endocrine Treatment of Transsexuals

Pre-treatment screening and appropriate regular medical monitoring is recommended for both FTM and MTF transsexual persons during the endocrine transition and periodically thereafter. Monitoring of weight and blood pressure, directed physical exams, routine health questions focused on risk factors and medications, complete blood counts, renal and liver function, lipid and glucose metabolism should be carried out.'

42. The basis for these recommendations is not explained. The GMC submitted that blood pressure is taken to identify any previously undiagnosed problems before treatment and to have a baseline blood pressure reading which can then be checked against future readings. It also contended that it was 'mandated' by WPATHSOC7.

43. The Tribunal considered that Dr Webberley was justified in being confident concerning *'previously undiagnosed problems'* on the basis that GIDS was prescribing GnRHa to Patient A. It accepted the argument for a baseline blood pressure reading. It did not consider that WPATHSOC7 'mandated' the taking of blood pressure prior to prescribing testosterone, since WPATHSOC7 is a guideline. Moreover table 2 of WPATHSOC7 lists risk factors for initiating hormone therapy. Hypertension is listed as a risk factor only if other risk factors are present. Dr Webberley stated in her reflective statement:

'The treatment with blockers or hormones would not be affected by blood pressure, and blood pressure would not have altered the management plan and is not affected by treatment.'

44. The Tribunal finds that the failure to arrange for Patient A to be adequately examined prior to prescribing testosterone treatment, including a physical examination to determine blood pressure amounted to misconduct which was not serious. It was misconduct because Dr Webberley did not follow recommendations, and it meant that she did not have a baseline reading, but it was not serious as she could be confident that Patient A did not have problems which militated against her prescribing testosterone, and therefore it does not go to impairment of fitness to practise.

<u>Paragraph 1(f)</u>

1 Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

f. in the alternative to paragraph 1e, record any assessment of Patient A's capacity to consent;

45. Dr S expressed the following view in his report on Patient A:

'In gender identity healthcare practice, I would expect, as a minimum, that the clinical record would include a statement that capacity had been assessed, that the patient was competent to give consent to specified interventions and that consent had been

given to specified interventions. Failure to include this information in [Patient A's] *clinical records falls below the standard expected of a reasonably competent General Practitioner with a special interest in gender care and sexual health.'*

46. Dr P expressed the following view in his report:

> *'There is no documented report on the evaluation, but it stated in her report of the first consultation that there were no mental health issues. The assessment of capacity of decision making in minors are very difficult and complex processes and they can 'in reality' only be done within a MDT approach as stated in the guidelines (SOC 7th and Endocrine Society). The documented assessment does not meet the adequate level of care.'*

47. Dr Q expressed the following view in his report:

> *'There is no indication of a formal assessment of capacity or Gillick competence. This is of concern as point 6 of GMC guidance on Decision Making and Consent requires:*
>
> > *Obtaining a patient's consent needn't always be a formal, time-consuming process. While some interventions require a patient's signature on a form, for most healthcare decisions you can rely on a patient's verbal consent, as long as you are satisfied they've had the opportunity to consider any relevant information (see paragraph 10) and decided to go ahead. Although a patient can give consent verbally (or non-verbally) you should make sure this is recorded in their notes.*

Pausing there, however, the Tribunal noted that this passage is derived from the 2020 edition of the guidance. It is not to be found in the 2008 edition which was the relevant edition in 2016 and 2017. Dr Q continued:

> *'Given the age of the patient and the nature of the treatment, capacity and competence would need to be assessed formally and documented thoroughly in line with the above GMC guidance and practice expectations derived from the Mental Capacity Act (2005) Code of Practice (which although for those over 16 years old, substantially inform competence practice for those under 16 years old).*
>
> *The Mental Capacity Act Code of Practice (MCA-CoP) provides that documentation of capacity assessments should be 'proportionate' to the decision in question. Although this applies to those over 16 years old the standards and practices are taken for use in child and adolescent services as a guideline to best practice.*
>
> *General Medical Council Guidance from Decision Making and Consent and, point 51 reads:*

> *You should take a proportionate approach to the level of detail you record. 'Good medical practice' states that you must include the decisions made and actions agreed - and who is making the decisions and agreeing the actions - in the patient's clinical records. This includes decisions to take no action.*

The administration of hormone treatment would reasonably necessitate a formal assessment and detailed, standalone documentation due to the therapeutic, but profound, impact of the treatment and [Patient A's]' youth and the complexities of the decision.

> • *There was a failure to sufficiently document any process of capacity or competence assessment*
> • *This standard of care is inadequate.'*

48. The context of this is that Dr Webberley did in fact assess Patient A's capacity to consent. The Tribunal considered that paragraph 51 of the GMC Consent Guidance 2008, upon which the GMC relied, which reads as follows:

'You must use the patient's medical records or a consent form to record the key elements of your discussion with the patient. This should include the information you discussed , any specific requests by the patient, any written, visual or audio information given to the patient, and details of any decisions that were made.'

is more concerned with treatment, rather than any capacity to consent.

49. The Tribunal noted paragraph 21 of GMP 2013 which provides:

'Clinical records should include:

- *Relevant clinical findings'*

50. The Tribunal noted that Dr Webberley in her reflective statement accepts that capacity to consent should have been recorded. She stated:

'Assessing competence is essential when treating minors, particularly if they do not have the benefits of parental involvement and support, as making medical decisions that can have lifelong consequences should not be undertaken lightly. This applies to all patients, and transgender patients are no different. I respect the tribunal's view regarding formally recording my findings of capacity to make decisions and understand treatment options and will seek to incorporate this more comprehensively into my future record keeping.'

51. The Tribunal has reached the view that Dr Webberley's failure to record her assessment amounted to misconduct which was not serious. As she had assessed Patient A's

capacity to consent, the principal purpose of recording that assessment was to protect herself from an allegation that she had not.

Paragraph 1(g)(i)(1,2 and 3)

1 Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

g provide adequate follow-up care to Patient A after initiating testosterone treatment in that you failed to :

(i) arrange assessments to evaluate Patient A's response to testosterone treatment, including:

1. psychological development monitoring;
2. physical development monitoring;
3. laboratory testing;

52. Dr S expressed his view that the standard of care provided by Dr Webberley in respect of follow-up care fell seriously below the standard of care expected of a reasonably competent GP with a special interest in gender dysphoria as follows:

'Not providing adequate follow-up: Safe and effective treatment of PATIENT A's gender dysphoria with testosterone demanded careful monitoring of their psychosocial and physical development, including laboratory assessments. There is no record of PATIENT A having any monitoring of their psychosocial and physical development or laboratory assessments. Concern about this was repeatedly expressed by PATIENT A's mother but Dr Webberley took no action.'

53. His reasons were:

'Careful monitoring of psychosocial and physical development, including laboratory assessments, was an essential prerequisite to the safe and effective care of PATIENT A when being treated for gender dysphoria with testosterone; without this, Dr Webberley put her patient at risk from its effects'

54. In her reflective statement, Dr Webberley stated:

'In the past I have often relied on patients contacting me at the end of their prescribed treatment period to arrange follow up and monitoring. A prescription for eg three or four months gives a neat timeframe for patients to contact me for a review and further treatment as necessary.

I have realised that this did not allow for all eventualities and I can see that eg Patient A suffered because I had not diarised an entry to follow him up.'

55. The finding of the Tribunal related to the period August 2016 to February 2017. The Tribunal accepted that, but for the communication breakdown between Patient A's mother and Dr Webberley, the system which Dr Webberley ran concerning follow up care might have been successful. However, that system depended on the patient needing to get in touch with his prescribing doctor in order to obtain further medication. It was a system which depended on nothing going wrong. There was no proactivity on the part of Dr Webberley. When the system broke down because of communication problems, she was unaware that it had. Dr Webberley did not initiate any or any effective contact. The submission on the part of Dr Webberley that the Tribunal should take into account that Patient A was under the care of GIDS – Professor F in September 2016 is not relevant. Dr Webberley was not aware of that fact. This was a treatment regime which she had commenced with the prescription of Testogel in April 2016. It was a life changing prescription which warranted proactivity on the part of the prescriber; it was not appropriate to rely on the patient, particularly as Dr Webberley was a GP with a special interest in gender dysphoria and therefore would have been well aware of the life changing ramifications.

56. The Tribunal determined that Dr Webberley's failure to provide adequate follow-up care to Patient A as found proved amounted to serious misconduct.

<u>Paragraphs 1(h) and (j)</u>

> 1 Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:
>
> > h inform Patient A's GP of the medication you were prescribing to A;
> >
> > j adequately communicate with Patient A's other treating physicians at the Gender Identity Clinic at University College London Hospitals after you commenced testosterone treatment;

57. The Tribunal considered these two sub-paragraphs of the Allegation together.

58. Dr S expressed his view that the standard of care provided by Dr Webberley in respect of failing to work collaboratively with colleagues fell seriously below the standard of care expected of a reasonably competent GP with a special interest in gender dysphoria as follows:

> *'Failure to work collaboratively with colleagues: Dr Webberley was undoubtedly aware that Prof. B was, as a member of the GIDS team, providing endocrine management of PATIENT A's gender dysphoria; she did not consult with or inform him that she had prescribed testosterone for PATIENT A. She was also aware that PATIENT A and their mother had withheld information about PATIENT A using testosterone from their GP, again compromising GP care. Dr Webberley failed to work collaboratively with*

colleagues. These communication failures fall seriously below the standard expected of a reasonably competent General Practitioner with a special interest in gender care and sexual health.'

59. His reasons were:

> *'Failure to work collaboratively with colleagues: By failing to inform Prof. B of her involvement in PATIENT A's care and by prescribing testosterone, she seriously compromised the safety monitoring and follow up that Prof. B endeavoured to provide, and her patient's safety. Her failure to communicate with PATIENT A's GP had similar effects. (Good Medical Practice, paragraph 35 and 36).'*

60. GMP 2013 provided, so far as is relevant to the issue, the following:

> *'16 In providing clinical care you must:*
> *a ....*
> *b ....*
> *c ....*
> *d .... consult colleagues where appropriate*
>
> *35 You must work collaboratively with colleagues, respecting their skills and contributions*
>
> *36 You must treat colleagues fairly and with respect.'*

61. The Tribunal noted that paragraph 16(d) of GMP sets out the obligation to consult colleagues where appropriate. Dr Webberley did not consider it appropriate to consult Patient A's GP or other treating physicians at GIDS since so doing would lead to the cessation of care by GIDS. As she explained in her reflective statement:

> *'It is difficult for doctors and patients who are placed in a position whereby there is a disagreement in the management and that that disagreement may impact on the care the patient receives. Patients may not want the other doctor to be aware of the management plan, yet the doctors understand that sharing information openly may result in the best outcome.*
>
> *I was very aware of situations where Professor F had taken very active steps to ensure that NHS support was withdrawn from patients who accessed my care. I was similarly aware of GPs who had phoned Professor F (as the NHS lead clinical for the UK) for advice after receiving correspondence from me, and were told that the care I was providing was substandard. I did not want either of these situations to affect the care that the patient needed with regards to their gender-affirmation.'*

62. The Tribunal did not consider the principles of continuity of care relied upon by the GMC and found in paragraph 44 of GMP 2013 assisted it in its determination of this.

63. The Tribunal recognised the importance of paragraphs 35 and 36 of GMP 2013. However, there was a tension between those paragraphs and the patient's right to confidentiality. Patient A and his mother did not wish to inform Patient A's GP or GIDS that he was receiving treatment from Dr Webberley. Although the GMC guidance 'confidentiality – good practice in handling patient information' was published in 2017, the principles were well known in the profession. Those relevant are as follows:

> *'Ethical and legal duties of confidentiality*
>
> *1 Trust is an essential part of the doctor-patient relationship and confidentiality is central to this. Patients may avoid seeking medical help, or may under-report symptoms, if they think their personal information will be disclosed by doctors without consent, or without the chance to have some control over the timing or amount of information shared.*
>
> *2 Doctors are under both ethical and legal duties to protect patients' personal information from improper disclosure. But appropriate information sharing is an essential part of the provision of safe and effective care. Patients may be put at risk if those who are providing their care do not have access to relevant, accurate and up-to-date information about them.*
>
> *The main principles of this guidance*
>
> > *8. The advice in this guidance is underpinned by the following eight principles.*
> >
> > > *a ….*
> > > *b ….*
> > > *c Be aware of your responsibilities. Develop and maintain an understanding of information governance that is appropriate to your role.*
> > > *d ….*
> > > *e Share relevant information for direct care in line with the principles in this guidance unless the patient has objected.*
> > > *f ….*
> > > *g ….*
> > > *h ….*
>
> *When you can disclose personal information*

9 Confidentiality is an important ethical and legal duty but it is not absolute. You may disclose personal information without breaching duties of confidentiality when any of the following circumstances applies.

a The patient consents, whether implicitly or explicitly, for the sake of their own care or for local clinical audit (see paragraphs 13–15).
b The patient has given their explicit consent to disclosure for other purposes (see paragraphs 13–15).
c The disclosure is of overall benefit to a patient who lacks the capacity to consent (see paragraphs 41–49).
d The disclosure is required by law (see paragraphs 17–19), or the disclosure is permitted or has been approved under a statutory process that sets aside the common law duty of confidentiality (see paragraphs 20–21).
e The disclosure can be justified in the public interest (see paragraphs 22–23).'

64. In the Tribunal's view, none of these circumstances applied.

65. Although Dr S did express the following view in the hearing, it was clear to the Tribunal that he was much exercised by the issue and said that it was up to each practitioner.

'My personal view is that I would not have prescribed without communicating to the other practitioners at UCLH. The way that I would approach that would have been to engage with the patient and exert all my persuasive powers at explaining to them why it was in the best interests to do so. If, despite that, they refused to give me consent to communicate, I would not have been willing to prescribe for them.'

66. Notwithstanding Dr S's view, the Tribunal determined that Dr Webberley's failure to work collaboratively with colleagues as alleged in sub-paragraphs 1(h) and (j) did not amount to misconduct at all.

<u>Paragraph 1(k)(iii)</u>

1 Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

k maintain an adequate record of Patient A's treatment in that entries in records were:

(iii) unclear as to who had made them.

67. Dr S observed in his report as follows:

'Inadequate record-keeping: The medical records kept by a reasonably competent GP are, in comparison with those kept by psychiatrists, usually in 'short note' or 'bullet point' form and omit most negative findings. However, allowing for this difference in record-keeping practice, Dr HW's patient records do not adequately describe the process of care for [Patient A's] gender dysphoria; they omit important clinical information. Entries by Dr HW are infrequent; some of her decisions are recorded by administrative staff, rather than personally, and it is not always evident as to who has made a record entry. The document appears to be a print-out of email correspondence and lacks important features of an Electronic Health Record.'

68. In her reflective statement, Dr Webberley stated:

'Having seen the difficulties that have been experienced by other people reading the print-outs of the GenderGP electronic medical record, I can see that it is very important to be very clear who has made an entry and what their role or qualifications are. Having worked in many different NHS settings, I am also very aware of the difficulties of transferring patient data from one electronic records system to another and viewing them on the new system.'

69. The Tribunal noted paragraphs 19 to 21 of GMP 2013 which provided as follows:

'Record your work clearly, accurately and legibly

19 Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.
20 ….
21 Clinical records should include:
a
b the decisions made and actions agreed, and who is making the decisions and agreeing the actions
c
d
e who is making the record and when.'

70. The Tribunal found that Dr Webberley breached these provisions of GMP. The name of the person making the record and his or her role should be clear to enable a reader to attach weight to the relevant record and for reasons of traceability, should enquiries need to be made at a future date. However, although it accepted that the role of the person making the record was not always set out, a wider perusal of the records would enable the reader to identify that person's role. In the light of the foregoing, the Tribunal determined Dr Webberley's failure to maintain an adequate record of Patient A's treatment as found proved amounted to misconduct which was not serious.

<u>Paragraph 3(a)(vi)</u>

> 3. Following an initial consultation with Patient B on <u>or about</u> ~~11~~ <u>10</u> August 2016, you failed to provide good clinical care in that you did not: **Amended under Rule 17(6)**
>
> > a. obtain an adequate medical history for Patient B, in that you failed to elicit information about:
> >
> > > vi smoking;

71. The GMC relied on the opinion of Dr S as follows:

> *'Dr Webberley's records do not document a medical history for [Patient B] adequate for diagnostic assessment and treatment planning. An 11th August 2016 entry in her records includes a description of [Patient B's] gender identity development, adaptations [Patient B] made to improve gender congruence, some information about their mental health a self-harm, sources of support and a discussion of [Patient B's] reproductive plans. [Patient B] was 16 at the time; there is no record of their general developmental history, record of age at onset of puberty and subsequent pubertal development, physical and mental health history, medication use, smoking, alcohol or substance use, or of any forensic history. If an adequate medical history had been taken but not documented, it would fall below the standard expected of a reasonably competent General Practitioner with a special interest in gender care and sexual health. If it had not been taken, this would fall seriously below the standard expected of a reasonably competent General Practitioner with a special interest in gender care and sexual health to a far greater extent than if it had not been documented.'*

72. The difficulty which the Tribunal encountered in respect of Dr S's opinion is that he did not express his opinion other than in respect of all the matters of medical history. The Tribunal only found a failure on the part of Dr Webberley to elicit information about smoking.

73. The Tribunal noted that there was a reason for enquiring about smoking identified in Dr Webberley's consent form which states:

> *'The risks of heart disease are greater if people in the family have had heart disease, if you are overweight, or if you smoke. The doctor can provide you with options to stop smoking.'*

74. She also explained in her reflective statement:

> *'I always ask about smoking as part of general health promotion, but I do not always enforce that discussion at the outset….*

It is my practice to ask about smoking but I would not limit treatment for gender dysphoria on the basis of the results. Health promotion advice such as smoking cessation, drug and alcohol intake and weight reduction forms part of an ongoing relationship with the patient in looking after their whole healthcare needs, and is better undertaken at a time where the likely chance of having an impact is maximal.

It is my experience from talking to patients, that teenagers who divulged that they smoked were often denied treatment by GIDS / UCLH. This apparently led to two outcomes, either they would lie about their smoking history, or they would be denied the care they needed.'

75. The Tribunal considered that obtaining information about smoking was a necessary component of taking a medical history; it was part of the process of taking a complete background history. However, there is no evidence that smoking would be a reason not to commence treatment. Moreover, it was something which Dr Webberley could deal with as treatment continued and as confidence in the doctor-patient relationship developed. The Tribunal has reached the view that Dr Webberley's failure to elicit information about Patient B's smoking history amounted to misconduct which was not serious.

Paragraph 3(a)(vii)

3. Following an initial consultation with Patient B on or about ~~11~~ 10 August 2016, you failed to provide good clinical care in that you did not: **Amended under Rule 17(6)**

a. obtain an adequate medical history for Patient B, in that you failed to elicit information about:

vii forensic history

76. The Tribunal noted Dr S's opinion recited in respect of paragraph 3(a)(vi) of this determination, insofar as it applies to forensic history. The Tribunal makes the same observation that Dr S expressed his opinion in the context of all matters of medical history as well as forensic history.

77. The Tribunal noted Dr Webberley's reflective statement in respect of its finding that she failed to take a forensic history.

'It has been my understanding that forensic medicine is involved with the history and examination of patients that have suffered physical or sexual abuse, and also the evaluation of patients who have committed crimes when suffering from a mental illness. I have never had any formal training in forensic history taking even though I have higher training in General Practice and in Sexual health.'

78. The Tribunal had some sympathy with Dr Webberley's position since the allegation is made by the GMC under the rubric of medical history. That is not the way in which Dr S expressed it.

79. In her reflective statement, Dr Webberley went on to state:

'I understand that forensic history appears in the 2019 NHS Service Specifications for adults, and I anticipate that is where Dr S is familiar with it. There it makes these recommendations for people referring in to Gender Identity Clinics:

> *Providers will not be unnecessarily prescriptive about the information to be included with the referrals (including insistence on use of template forms) but referrers will be encouraged to provide the following information...........*
>
> *a. Forensic history*

It was my experience that many adolescents who were assessed by GIDS were asked extensive questions about the possibility of past sexual abuse, and Patient A in his oral evidence remembered his assessments and told the Tribunal,

> *There was a lot about what felt like uncomfortable questions about myself and stuff and, yes, just stuff like that, trying to figure out my diagnosis.*

I wanted to make sure that my own practice was not in any way disrespectful to trans patients while still eliciting necessary information.

In my experience, gender dysphoria that is not recognised or supported, causes worsening of mental health and the consequent behavioural difficulties that can be associated with that. I have commonly heard of disruptive and antisocial behaviour from distressed teenagers with gender dysphoria. It seems that this was the case with Patient B.

The tribunal found that,
Dr Webberley should have made proper enquiry about Patient B's forensic history since such a history could assist her in regard to the treatment which she should prescribe for him.'

I do not think that questioning this patient in relation to any forensic history would have assisted me in the treatment I would or should prescribe. It is my experience that gender-affirming care relieves the mental health difficulties experienced by transgender adolescents, and any associated disruptive or antisocial behaviours then decrease.'

80. The Tribunal noted Dr Webberley's reference to 2019 NHS Service Specifications for adults. Patient B was aged 16 at the time. Further it noted Mr Stern's observation that WPATHSOC7 makes no reference to taking a forensic history or to criminal convictions.

81. The Tribunal considered that obtaining information about forensic history was an important component of taking a full history. It considered that it is important for the doctor to be aware of any history of antisocial behaviour as well as self-harm, poor school performance etc as general markers of dysphoria. Having this history would be helpful in assessing a patient's response to treatment. However, it accepts that a forensic history would not be a reason not to commence treatment. Moreover, it was something which Dr Webberley could deal with as treatment continued and as confidence in the doctor-patient relationship developed. The Tribunal has reached the view that Dr Webberley's failure to elicit information about Patient B's forensic history did not amount to misconduct.

Paragraph 3(b)(ii)(3)

> 3. Following an initial consultation with Patient B on or about ~~11~~ 10 August 2016, you failed to provide good clinical care in that you did not: **Amended under Rule 17(6)**
>
> > b. arrange for Patient B to be adequately examined prior to prescribing testosterone treatment, including:
> >
> > > ii a psychological assessment to:
> > >
> > > > 3 determine Patient B's mental health needs;

82. The Tribunal had regard to WPATHSOC7 which included the following under the heading of:

'Tasks related to Assessment and Referral

1. Assess Gender Dysphoria

….

The role [of the mental health professional] includes making reasonably sure that the gender dysphoria is not secondary to, or better accounted for, by other diagnoses.

Mental health professionals with the competencies described above (hereafter called "a qualified mental health professional") are best prepared to conduct this assessment of gender dysphoria. However, this task may instead be conducted by another type of health professional who has appropriate training in behavioral health and is competent in the assessment of gender dysphoria, particularly when functioning as

part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy. This professional may be the prescribing hormone therapy provider or a member of that provider's health care team.

2. Provide Information Regarding Options for Gender Identity and Expression and Possible Medical Interventions

….
3. Assess, Diagnose, and Discuss Treatment Options for Coexisting Mental Health Concerns

Clients presenting with gender dysphoria may struggle with a range of mental health concerns (Gómez-Gil, Trilla, Salamero, Godás, & Valdés, 2009; Murad et al., 2010) whether related or unrelated to what is often a long history of gender dysphoria and/or chronic minority stress. Possible concerns include anxiety, depression, self-harm, a history of abuse and neglect, compulsivity, substance abuse, sexual concerns, personality disorders, eating disorders, psychotic disorders, and autistic spectrum disorders (Bockting et al., 2006; Nuttbrock et al., 2010; Robinow, 2009). Mental health professionals should screen for these and other mental health concerns and incorporate the identified concerns into the overall treatment plan. These concerns can be significant sources of distress and, if left untreated, can complicate the process of gender identity exploration and resolution of gender dysphoria (Bockting et al., 2006; Fraser, 2009a; Lev, 2009). Addressing these concerns can greatly facilitate the resolution of gender dysphoria, possible changes in gender role, the making of informed decisions about medical interventions, and improvements in quality of life.'

83. The Tribunal accepted that Dr Webberley diagnosed gender dysphoria, and treated Patient B accordingly, and that she was treating the principle presenting condition, something which may have had the effect of addressing, alternatively ameliorating all of Patient B's presenting signs and symptoms. However, it finds that such an approach does not mean that the patient's mental health needs were directly explored through psychological assessment. The Tribunal has perused further GenderGP's record of care, and noted that in addition to the face to face consultation in August 2016, which was followed by a letter she drafted to his GP, Dr Webberley had elicited information from Patient B via a questionnaire which included the following questions under the rubric:

'Family and Health

• Can you tell me about your close family (Names of birth parents, siblings and current living arrangements
• Can you tell me about your education so far– schools attended with dates
• Please give details of your medical history (Childhood Illnesses)
• Has there been or are there any significant family life events (e.g. separations-parents leaving the family, bereavements or moving places/areas)

> *• Are any of your suffering from or have suffered from health or family mental health issues **
> *• Have you ever wanted to harm/hurt yourself and if so why ?*
> *• Have you ever taken part in any other risk taking behaviours (e.g. drugs, alcohol)*
> *• Do you have any other problems we should be aware of (e.g. mood disorders, autistic spectrum and learning disabilities.) **
> *• Have you ever felt uncomfortable with how an adult has acted towards you? • Have you ever been bullied?'*

84. The Tribunal noted the terms of the paragraph of the Allegation under consideration. Whilst the GenderGP record makes no reference to an assessment by Dr Webberley of Patient B's mental health needs, it will accept that it is inconceivable that Dr Webberley would not have made some sort of a psychological assessment of those needs given that she was appraised of relevant information in this regard following receipt of the completed questionnaire and having met Patient B in person. WPATHSOC7 recited above refers to:

> *'Possible concerns include anxiety, depression, self-harm, a history of abuse and neglect, compulsivity, substance abuse, sexual concerns, personality disorders, eating disorders, psychotic disorders, and autistic spectrum disorders.'*

85. Whilst the information sought and elicited from Patient B may not have addressed absolutely every one of these concerns, the Tribunal does not consider that it would be appropriate to find that her actions amounted to misconduct. It has found that Dr Webberley was competent as a mental health professional. She had the information before her to enable her to make her own assessment and, if necessary, to arrange for Patient B to be assessed by another. She chose not to do the latter. It notes in passing that she was prepared, when she deemed it necessary, to refer a patient for psychological assessment.

Paragraph 3(d)(i & ii)

> 3. Following an initial consultation with Patient B on or about ~~11~~ 10 August 2016, you failed to provide good clinical care in that you did not: **Amended under Rule 17(6)**
>
> d conduct an adequate assessment of Patient B prior to testosterone treatment, including eliciting details of:
>
> i height;
>
> ii weight

86. The Tribunal determined to consider these two sub-paragraphs of the Allegation together.

87. In its determination on the facts, the Tribunal considered that eliciting details of height and weight three months before treatment should not properly be regarded as "prior to treatment".

88. In her reflective statement, Dr Webberley stated:

> *'Monitoring growth is of utmost importance during pubertal induction. The guidance are not specific in their recommendations, but it is clearly important to ensure that adolescents who are having their puberty induced and maintained iatrogenically are growing at the same pace as their cisgender counterparts. The standard way to measure and monitor growth in young people is to plot their height and weight on growth charts. This gives you a picture of which 'centile' the child is growing along, understanding that there are genetic differences in children's body size and shape.*
>
> *The importance is to make sure that growth is happening and that weight and height and the development of secondary sex characteristics are in line with expectations for adolescent growth, and that the young person stays on their expected centile - not abnormally dropping to a lower one or escalating to a higher one.*
>
> *Hence it is the plotted position on the growth chart rather than the absolute values that are most important. Measurements taken before the commencement of pubertal induction can be taken in any reasonable timeframe so as to give a baseline centile position.'*

89. The Tribunal regarded Dr Webberley's statement as a good exposition as to why height and weight are important. It endorses Dr S's opinion which he expressed as follows:

> *'An adequate examination, by her or by another medical practitioner, is not described in Dr Webberley's records. Important omissions from her record of the assessment include height, weight, blood pressure and the Tanner staging of* [Patient B's] *pubertal development, specifically the stage of their pubic hair growth and breast development. These data are essential for deciding on the appropriateness of prescribing a GnRHa and testosterone. If this examination had been done but not documented, it would fall seriously below the standard expected of a reasonably competent General Practitioner with a special interest in gender care and sexual health. If an examination had not been done, this would fall seriously below the standard expected of a reasonably competent General Practitioner with a special interest in gender care and sexual health to a far greater extent than if it had not been documented. In my opinion, prescribing testosterone without this information would be reckless.'*

90. When he wrote his report, Dr S had not seen the relevant notes and so was unaware that Dr Webberley had in fact elicited Patient B's height and weight, albeit three months before treatment. Moreover, as the Tribunal has noted elsewhere, Dr S has expressed his view in respect of a range of matters.

91. Taking into account the fact that Dr Webberley did elicit information concerning Patient B's height and weight albeit three months before treatment, the Tribunal determined that her failure to so do prior to treatment amounted to misconduct which was not serious.

Paragraph 3(d)(iii)

> 3. Following an initial consultation with Patient B on or about ~~11~~ 10 August 2016, you failed to provide good clinical care in that you did not: **Amended under Rule 17(6)**
>
> > d conduct an adequate assessment of Patient B prior to testosterone treatment, including eliciting details of:
> >
> > > iii blood pressure

92. The Tribunal had regard to its reasoning in relation to paragraph 1(b)(i) of the Allegation which concerned Patient A. In contrast to the position in respect of Patient A, Dr Webberley did not have any reassurance that Patient B was a fit and healthy 16 year old as he had not been assessed by GIDS, and cleared for ongoing GnRHa treatment. However, as Dr Webberley was not prescribing GnRHa treatment for Patient B, blood pressure was not something which she would need to know other than to establish a baseline.

93. In these circumstances, the Tribunal finds that her failure to arrange for Patient B to be adequately examined prior to prescribing testosterone treatment, including a physical examination to determine blood pressure amounted to misconduct which was not serious. It was misconduct because Dr Webberley did not follow recommendations, and it meant that she did not have a baseline reading, but it was not serious as there was no medical reason for Dr Webberley to ascertain Patient B's blood pressure before commencing treatment with testosterone.

Paragraph 3(g)

> 3 Following an initial consultation with Patient B on or about ~~11~~ 10 August 2016, you failed to provide good clinical care in that you did not: **Amended under Rule 17(6)**
>
> > g. In the alternative to paragraph 3f, record any assessment of Patient B's capacity to consent;

94. The context of this is that Dr Webberley did in fact assess Patient B's capacity to consent. The Tribunal had regard to its reasoning in relation to paragraph 1(f) of the Allegation.

95. The Tribunal has reached the view that Dr Webberley's failure to record her assessment amounted to misconduct which was not serious. As she had assessed Patient B's

capacity to consent, the principal purpose of recording that capacity was to protect herself from an allegation that she had not.

Paragraph 3(h)

3 Following an initial consultation with Patient B on <u>or about</u> ~~11~~ <u>10</u> August 2016, you failed to provide good clinical care in that you did not: **Amended under Rule 17(6)**

h. provide adequate follow-up care to Patient B after initiating treatment in that you failed to arrange for review consultations;

96. The Tribunal had regard to its reasoning when making its findings of fact in relation to this sub-paragraph of the Allegation and in respect of misconduct concerning a similar allegation relating to Patient A – paragraph 1(g) of the Allegation. The Tribunal determined that Dr Webberley's failure to provide adequate follow-up care to Patient B as found proved amounted to serious misconduct.

Paragraph 5(a)(i)(2&3)

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

a. did not arrange for Patient C to be <u>adequately</u> examined prior to prescribing ~~testosterone and GnRHA~~ <u>GnRHa</u> treatment, including: **Amended under Rule 17(6)**

i a physical examination to determine:

2. height;
3. weight;

97. The Tribunal considered these two sub-paragraphs of the Allegation together.

98. In its determination on the facts, the Tribunal considered that eliciting details of height and weight four to five months before treatment could not properly be regarded as *'prior to treatment'*.

99. The Tribunal considered a similar allegation in relation to paragraph 3(d)(i) and (ii) of the Allegation.

100. Taking into account the fact that Dr Webberley did elicit information concerning Patient C's height and weight, albeit four to five months before treatment, the Tribunal determined that her failure to so do prior to treatment amounted to misconduct which was not serious.

Paragraph 5(a)(ii)(1&2)

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

a. did not arrange for Patient C to be **adequately** examined prior to prescribing ~~testosterone and GnRHA~~ GnRHa treatment, including: **Amended under Rule 17(6)**

ii full psychological pre-diagnostic input to:

1. Clarify diagnoses;
2. Explore additional factors, including Attention Deficit Hyperactivity Disorder.

101. The Tribunal considered these two subparagraphs together.

102. The Tribunal makes clear that in finding this paragraph of the Allegation proved, it did not find Dr Webberley failed to explore attention deficit hyperactivity disorder. It was satisfied that she had done that by arranging that Patient C consult with Dr V. Its findings related to the matters to which it referred under WPATHSOC7 namely:

• other possible alternative diagnoses that may provide an alternative explanation for the dysphoric feelings or complicate them;
• other coexisting mental health issues in order for these to be optimally managed prior to, or concurrent with treatment for gender dysphoria.

103. The Tribunal recognised that the approach which Dr Webberley adopted to these “other matters” in respect of Patient C echoed her approach in respect of Patient B. There was a face to face consultation and the same (completed) questionnaire.

104. The Tribunal adopts the same reasoning upon which it relied when considering paragraph 3(b)(ii)3. It does not consider that it would be appropriate to find that her actions amounted to misconduct.

Paragraph 5(b)

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

b did not record the details of any assessment as set out in paragraph 5(a) above.

105. This matter refers to Dr Webberley's failure to record the details of any assessment of Tanner staging of Patient C's pubertal development. The Tribunal found that Dr Webberley was not obliged to carry out an examination of Patient C but she should have recorded the detail of her assessment.

106. The GMC relies on Dr S who stated:

> *'Important omissions from her record of the assessment include height, weight, blood pressure and the Tanner staging of* [Patient C's] *pubertal development, specifically the stage of their pubic hair growth and breast development. These data are essential for deciding on the appropriateness of prescribing a GnRHa and testosterone. If this examination had been done but not documented, it would fall below the standard expected of a reasonably competent General Practitioner with a special interest in gender care and sexual health. I address the issue of record keeping in my response to question 11. If an examination had not been done, this would fall seriously below the standard expected of a reasonably competent General Practitioner with a special interest in gender care and sexual health to a far greater extent than if it had not been documented. In my opinion, prescribing a GnRHa or testosterone without this information would be reckless.'*

107. So far as is germane to this issue, Dr S's reference to question 11 of letter of instruction the GMC provided would appear to be the following:

> *'The record of monitoring of physical development at follow up is also inadequate, as described above. This falls seriously below the standard expected of a reasonably competent General Practitioner with a special interest in gender care and sexual health.'*

108. Comparing the two sections of his opinion, it is not clear whether Dr S is stating the absence of a record is seriously below the relevant standard or, as seems more likely, simply below.

109. Moreover, Dr S expresses his view in relation to a compendium of record keeping failures, so that it is difficult to determine the gravity he attaches to a single omission.

110. The GMC also relies on paragraphs 19 to 21 of GMP 2013 as follows:

> *'Record your work clearly, accurately and legibly*
>
> *19 Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.*
>
> *20 You must keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection law requirements.*

21 Clinical records should include:
a relevant clinical findings
b the decisions made and actions agreed, and who is making the decisions and agreeing the actions
c the information given to patients
d ….
e ….'

111. Dr Webberley's clinical record includes the following:

'[Patient C] started puberty when he was 9 years old and it seems to be progressing quite quickly. He has early stages of breast development but hasn't started his periods yet.'

112. Dr Webberley did not therefore record a clinical finding as to Patient C's pubertal development by reference to Tanner staging.

113. Mr Stern submits that any following clinician would know that puberty had been reached as blockers had been prescribed.

114. The Tribunal accepts that the parameters underpinning Tanner staging were recorded and that any competent doctor taking on the care of Patient C would be able to understand the Tanner staging from the record. It was, moreover, implicit that Patient C was at least in Tanner stage 2 given that Dr Webberley prescribed GnRHa. There is no suggestion that Patient C's care was compromised or would be put at risk by Dr Webberley's failure to record the Tanner stage obtained from her assessment.

115. In all the circumstances, the Tribunal finds that Dr Webberley's failure to record the details of her assessment of Tanner staging of Patient C's pubertal development amounted to misconduct which was not serious.

Paragraph 5(d)(iii)

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

d. Advised Patient C as to the risks of ~~GnRHA~~ GnRHa before commencing treatment without: **Amended under Rule 17(6)**

iii. discussing the risks to Patient C's fertility;

116. The Tribunal was of the view that, for the GMC, Dr T's assessment of the obligation was the most helpful. She said in evidence:

'If it [fertility] was not discussed directly with the young person in my opinion that would be a failure of informed consent. Although we're aware that the blockers have a reversible effect on fertility it's something that we consider right from the beginning of conversations about blockers and for lots of reasons. So firstly it gives us a chance to think about capacity – does the young person understand the impact of the blockers and the impact of potentially later on other cross-sex hormones? So the young person would be able to demonstrate their understanding and then we're able to fill in any gaps or explain.

Also if a young person does want to take steps to preserve fertility that is quite a lengthy process and it needs to be commenced. Within KOI most of our young people are only on blockers for around a year so if they do want to preserve fertility, they need to get the referral commenced as quickly as possible so that they can go through that process and it doesn't cause any delays to them being able to start cross-sex hormones when their period of time on blockers is completed. So it's something that needs to be discussed with young people prior to beginning treatment so that you can be sure that they have considered the impact of this treatment pathway that they're starting because even though the blockers have a reversible effect it is the beginning of a pathway that does lead to cross-sex hormones in most cases which do have an irreversible effect on fertility so it's important that the young person is very clear about that and that you've discussed it with them.'

117. However, Dr U identified the dilemma facing a doctor in Dr Webberley's position. He said, in answer to the following question:

'Q Where an issue has been flagged up in the notes that the issue of fertility had not been addressed with the patient and needed to be addressed prior to the commencement of blockers, is that something that should be addressed before blockers are prescribed with the patient?
A I think that's a very interesting question because the use of GnRH analogues by themselves do not impact fertility so that, you know, if someone uses GnRH analogues to pause puberty and then it's discovered that their male puberty is the right puberty for them, they come off GnRH analogues and progress through puberty and have, we would imagine, normal fertility. Just like we use GnRH analogues for kids with precocious puberty and don't anticipate fertility compromise.

I think a challenge of talking about fertility with someone of this age group is that they're not equipped to understand fertility very well and that's another reason why GnRH analogues are used to allow more time and maturity for a patient to be equipped to discuss issues of fertility that can be compromised with use of cross-sex hormones. But I oftentimes bring up the topic of fertility only to say that when embarking down a pathway towards potential cross-sex hormones and at that point a discussion about fertility will be important, but I'm not sure that fertility is a topic well received by patients in the age group that are considering blockers and so it is one of the more challenging sort of questions to know how to navigate that.'

118. Dr Webberley stated in her reflective statement:

> *'I had not adequately discussed fertility preservation with Patient C and his mother at our consultation and went back to clarify further in writing.'*

119. She continued:

> *'The discussion around fertility is a continual one over many years, with many trans adolescents being much more able to enter into these discussions once the acute fear of pubertal development has subsided because of blocker treatment, and they can take more time to consider the next stages.'*

120. The Tribunal was mindful of the point that the moment to which the charge relates was not the last opportunity for Dr Webberley to discuss the risks to fertility with Patient C, although it did recognise the point that the vast majority of patients who are treated with GnRHa go on to take gender affirming hormones. It also noted that Dr Webberley was aware of her omission and sought to correct it when she wrote to Patient C's mother on 26 February 2017, but this was long after the consultation which took place on 9 November 2016 and significantly before Dr Webberley wrote the prescription on 29th April 2017.

121. The Tribunal considered that the probable permanent suppression of fertility was a matter which ought to have been raised by Dr Webberley with Patient C at the time of the consultation. It recognised that puberty suppression is reversible, and that discussing fertility with a young person is difficult, and that it takes time for a person to think through such weighty matters. However, it is in evidence that most patients opting for puberty suppression will later request GAH. Therefore, the initial consultation was a key juncture; Dr Webberley should have started the ball rolling in respect of fertility so that Patient C could have time to absorb the information and reflect on it.

122. In the circumstances, the Tribunal find that Dr Webberley's omission to discuss the risks to Patient C's fertility before commencing treatment amounted to misconduct which was serious.

Paragraphs 5(f) and 5(g)

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

f. in the alternative to Paragraph 5e, did not record any assessment of Patient C's capacity to consent;

g. did not record Patient C's reasoning ability and competence with regards to his treatment;

123. The Tribunal considered these two sub-paragraphs of the Allegation together.

124. The context of this is that Dr Webberley did in fact assess Patient C's capacity to consent. The Tribunal had regard to its reasoning in relation to paragraph 1(f) of the Allegation.

125. The Tribunal has reached the view that Dr Webberley's failure to record her assessment amounted to misconduct which was not serious. As she had assessed Patient C's capacity to consent, the principal purpose of recording that capacity was to protect herself from an allegation that she had not.

Paragraph 5(i)(i)

> 5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:
>
> > i. Did not maintain an adequate record of Patient C's care in that entries in records were:
> >
> > > i. Infrequent;

126. Dr S expressed the following view:

> *'The medical records kept by a reasonably competent GP are, in comparison with those kept by psychiatrists, usually in 'short note' or 'bullet point' form and omit most negative findings. However, allowing for this difference in record-keeping practice, Dr Webberley's patient records do not adequately describe* [Patient C's] *care. Entries by Dr Webberley are infrequent; some of her decisions are recorded by administrative staff, rather than personally, and it is not always evident as to who has made a record entry. The document appears to be a print-out of email correspondence and lacks important features of an Electronic Health Record.'*

127. The GMC relies on paragraphs 19 to 21 of GMP 2013, recited elsewhere in this determination.

128. The Tribunal does not attach much significance to Dr Webberley's failure to record:

- the Tanner staging of Patient C's pubertal development;
- her assessment of Patient C's capacity to consent;
- Patient C's reasoning ability and competence with regards her treatment.

129. Were these the only matters to be considered in respect of misconduct, the Tribunal would not have found that they amounted to serious misconduct for the reasons set out elsewhere in this determination.

130. Concerning Dr V's report, Mr Stern recites a narrative in his submissions which the Tribunal does not accept. In particular he submits:

- On Monday 13th February GenderGP sends a response (to Mrs C). This makes it clear that Dr Webberley had considered the report and found no reasons not to proceed with the treatment;
    - The Tribunal finds, however, that there is no suggestion in the note that Dr Webberley considered the report and found no reasons not to proceed with the treatment.
- Thursday February 23rd a draft letter is compiled incorporating Dr Webberley's note on the report;
    - The Tribunal finds, however, that the note is not to be seen in the record.

131. The Tribunal does not resile from the determination which it made in respect of Dr V's report dated 25 January 2017, namely that:

'notwithstanding the huge significance of it to Patient C and his mother, Dr Webberley did not make any record that she had personally read it and reflected upon it, nor whether she was satisfied with it, nor how she considered it should inform her proposed treatment of Patient C's gender dysphoria, nor as to what the next steps should be. Indeed, it was not until 27 February 2017 that Dr Webberley made any reference to the fact that a psychologist 'had been seeing Patient C' even though GenderGP had received Dr V's report on 9 February 2017.'

132. The Tribunal find this omission to be sufficiently serious so as to amount to misconduct. Continuity of care requires that a clinician taking over the care of a patient has access to a clear, intelligible and sufficient record of the previous clinician's involvement with that patient. HW's records were, when made, cursory, and the record omits important matters, including what she made of Dr V's report.

Paragraph 5(i)(iii)

5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:

i. Did not maintain an adequate record of Patient C's care in that entries in records were:

iii unclear as to who had made them;

133. The Tribunal relies upon its reasoning when considering paragraph 1(k)(iii) regarding Patient A.

134. In the light of the foregoing, the Tribunal determined Dr Webberley's failure to maintain an adequate record of Patient C's treatment as found proved amounted to misconduct which was not serious.

Paragraph 9

> 9. On 10 January 2017, during an ~~un~~announced CQC inspection of Dr Matt Limited, you were the Safeguarding Lead and you: **Amended by the Tribunal**
>
> a. were unaware of the safeguarding policy;
>
> b. had never seen a copy of the safeguarding policy.

135. The Tribunal considered these two sub-paragraphs of the Allegation together.

136. The Tribunal took into account Dr Webberley's reflective statement in which she stated:

> *'I should have taken more steps to ensure that there was a formal written policy in place. I understand that even though the service at that time was small with only a few team members working closely together as a team, it was still important to make sure that documentation was in place that would stand up to scrutiny and be a reference point for staff.'*

137. The GMC's submission to the Tribunal included the following:

> *'Dr Matt Ltd was another online prescribing business for which Dr Helen Webberley was the Registered Manager and Safeguarding Lead. As the Registered Manager of the provider, Dr Webberley, had a legal responsibility to ensure the Provider Dr Matt Limited met various regulations, and she was accountable for the service if it did not. As the Safeguarding Lead, Dr Helen Webberley also had the responsibility to ensure all safeguarding issues were addressed.'*

138. Mr Stern submitted that Dr Webberley had no obligation to be aware of the safeguarding policy of DMC, that being the policy which was provided to the CQC by DMC members of staff when the announced CQC inspection took place on 10 January 2017. However, the Tribunal noted DMC was the parent company of Dr Matt Limited and that Dr Matt Limited was permitted to conduct its business from DMC premises, albeit on an online basis. When the CQC inspector asked for a copy of the safeguarding policy from Dr Matt Limited, they were provided with the DMC safeguarding policy. It considered that Dr

Webberley had every reason as Registered Manager of Dr Matt Limited to be aware of the safeguarding policy which pertained to the business where it operated.

139. The Tribunal accepted the GMC's submission. The safeguarding policy of an online prescribing business regulated by the CQC was a matter of great importance and significance for the protection of the client group which the business served. That client group may well have included vulnerable persons. It was not something that Dr Webberley as the CQC Registered Manager and Safeguarding Lead could ignore.

140. The Tribunal determined that it was serious misconduct on the part of Dr Webberley, as the CQC Registered Manager and Safeguarding Lead of Dr Matt Limited not to be aware of the safeguarding policy and not to have ever seen a copy of it.

Paragraphs 10(a), 11 and 12

> 10. on 9 May 2017 you submitted to the Interim Orders Tribunal ("the IOT") a:
>
> > a. signed witness statement in which you stated that you had been a member of the RCGP since 1996;
>
> 11. You have never been a member of the RCGP.
>
> 12. You submitted information to the IOT which was untrue.

141. The Tribunal considered the three paragraphs together.

142. The Tribunal made it clear in its determination on facts that it interpreted the word *'untrue'* in paragraph 12 of the Allegation as *'inaccurate'*. It addresses misconduct on that basis. It also noted that it dismissed the paragraphs of the Allegation which alleged that (at the material time) Dr Webberley knew the information which she submitted to the IOT was "untrue" (paragraph 13), and that she was acting dishonestly (paragraph 14).

143. The Tribunal reminded itself of the letter which Dr ZZ of the RCGP sent to Dr Webberley on 19 April 2017. In that letter, she stated:

> *'As Assistant Honorary Secretary of the College I must inform you that you are not currently a member of the College. Please note that passing the MRCGP examination does not entitle you to use the letters MRCGP after your name unless you are a member in 'good standing' (e.g. by paying your annual subscription). I would be grateful, therefore, if you would remove the letters from the website.'*

144. That letter was sent to Dr Webberley some 19 days before Dr Webberley's statement to the IOT of 8 May 2017. As mentioned in its factual determination, Dr Webberley admitted having received the RCGP letter of 19 April 2017. She went on to state:

> *'Throughout my career, I have always used MRCGP as a post-nominal and have often stated that I have Membership of the Royal College of General Practitioners. I have never intended for this to be taken as an indication of being a yearly subscriber to the College, but simply used the term to indicate my level of qualification and my success in passing the membership exam. The exam is still called the MRCGP exam, and the qualification is known as gaining the Membership of the Royal College of GP's exam.'*

145. Dr Webberley also stated that, upon receipt of the RCGP letter, she removed MRCGP from her letterheads and email signatures and also informed and requested third-party websites to do to do the same. Further, she stated:

> *'On 24 April 2017 I had the PACE interview with HIW and on 25 April 2017 the Health Board Reference Panel suspended me from Medical Performers List. On 28 April 2017 I received notice of the IOT hearing to be held on 09 May 2017. All of these things were very new to me and I do not think I gave the RCGP letter the due regard that it deserved.'*

146. In her oral evidence to this Tribunal, Dr Webberley stated words to the effect:

> *'I did receive that letter. That was in April when my whole world turned upside down - I had ABUHB - ref panel - IOT. Yes, letter dated 19 April 2017 - don't know when I received it - overwhelmed - sorry for error.'*

147. The Tribunal determined that as a doctor, Dr Webberley had an obligation to understand that she was not entitled to use the post nominal MRCGP, and this was reinforced to her by the letter from Dr ZZ dated 19 April 2017. It also determined that there was a degree of confusion for a doctor who had passed the membership examination of the RCGP, as the word 'membership' is used both as the title of the examination and separately in the post-nominal letters used by those who belong to the College. It did not consider that she deliberately sought to mislead the IOT by signing her witness statement as she did. In these circumstances, the Tribunal determined that her actions amounted to misconduct which was not serious.

Paragraph 18

> 18. On 25 April 2017 you were suspended from the Medical Performers List and you failed to notify Frosts Pharmacy of this.

148. Dr Webberley's obligation to notify Frosts Pharmacy Limited arose from paragraph 76 of GMP 2013 which reads:

'If you are suspended by an organisation from a medical post, or have restrictions placed on your practice, you must, without delay, inform any other organisations you carry out medical work for and any patients you see independently.'

149. The Tribunal recognised that Dr Webberley had stood back from her role at Frosts Pharmacy several months before 25 April 2017 when she was suspended from the Medical Performers List. Had she not worked for Frosts Pharmacy after that date, she would not have been under any obligation to notify them of that suspension. However, there was an occasion when she did perform some work for them after that suspension. This was on 18 May 2017 when she and Dr SS had just arrived at Malaga Airport in Spain. Dr SS, who had taken over her work when she stood back from it, had logged into Frosts Pharmacy and was providing online services for clients. Likewise, although fleetingly – the work lasted a matter of a few minutes - Dr Webberley logged into Frosts Pharmacy and carried out a very small number of tasks in respect of clients. To that extent, she worked for Frosts Pharmacy and therefore should have notified them of her suspension from the Medical Performers List.

150. The Tribunal finds that this was a breach of her obligation to notify Frosts Pharmacy of her suspension. Dr Webberley ought to have known and recognised her obligations which were either not to work for Frosts Pharmacy on 18 May 2017 or to notify them that she was suspended by MPL before she carried out the work. They were entitled to know for legitimate reputational reasons. The Tribunal determined that her action as found proved did amount to misconduct which was serious.

Paragraph 22(a)

22 During the Review, you knew that you were:

a. the subject of open GMC investigations;

151. This is a purely factual allegation in respect of which misconduct could not be imputed.

Paragraph 24

24 Alongside Dr SS, you operate and control the company know as GenderGP, through which you provided care and treatment.

152. This is a purely factual allegation in respect of which misconduct could not be imputed.

The Tribunal's Determination on Impairment

Paragraphs 1(g)(i)(1, 2 and 3) and 3(h)

153. Dr Webberley set out her explanation in her reflective statement as to why she did not set up a pro-active review system. It is recited in the Tribunal's determination on misconduct. The Tribunal understood that explanation but it was surprised that it had not occurred to Dr Webberley at the time that it carried significant risks for her patients if for some reason they did not communicate with her for further prescriptions. The Endocrine Society Guidelines 2009 make the following recommendations in respect of GAH treatments respectively:

> *'We recommend monitoring pubertal development as well as laboratory parameters. (Table 10). Sex steroids of the desired sex will initiate pubertal development, which can be (partially) monitored using Tanner stages. In addition, the sex steroids will affect growth and bone development as well as insulin sensitivity and lipid metabolism, as in normal puberty.'*

154. The Tribunal finds that the administration of exogenous testosterone to induce a FTM trans-puberty is likely to have systemic effects. This is evidenced by and consistent with the Endocrine Society Guidelines 2009, which include recommendations that a range of parameters be monitored during therapy. These include markers of therapeutic efficacy, such as height, weight, Tanner stage and testosterone levels, and markers of therapeutic safety such as liver function, lipid levels and blood pressure.

155. The Tribunal considered it to be axiomatic that when treating a transgender person for dysphoria, the patient's psychosocial development in response to therapy should be monitored. Dr Webberley had accepted that her failure to proactively monitor Patient A and Patient B during testosterone therapy was a failing this regard.

156. The Tribunal regarded this failing as remediable. The first step is for Dr Webberley to demonstrate that she has developed sufficient insight to enable her to remediate them. Dr Webberley has written two short paragraphs in her reflective statement setting out what went wrong. This was not an extensive reflection, but it was consistent with her style of communication and to the point. The Tribunal accepted that she has obtained insight.

157. As to the remediation which she has carried out, it is encapsulated in the following passages from her reflective statement as follows:

> *'For the best care, I feel it would be best to advise patients exactly when I wanted to review their care, and also to implement a calendar reminder system to check up on patients who do not come forward of their own accord.*
>
> *Many new electronic medical records systems have this function built in, so you can easily set a reminder as to when you would like to follow up that patient and are notified and reminded if they do not return.'*

158. The Tribunal recognised that Dr Webberley has not been directly involved in clinical care in Gender GP since the imposition of an interim order in April 2017, but she does

communicate with her colleagues in that organisation. The Tribunal was satisfied that Dr Webberley would implement these changes upon a return to practise.

159. The Tribunal therefore does not find that Dr Webberley's fitness to practise is impaired in respect of her misconduct relating to follow-up care based on public protection grounds.

160. The Tribunal considered whether it should make a finding of impairment based upon the public interest alone. Having regard to Dame Janet Smith's categorisation of cases which may lead to a finding of impairment, the Tribunal has found that Dr Webberley's misconduct in this regard did put Patients A and B at unwarranted risk of harm. In the Tribunal's view an informed member of the public would be surprised if a finding of impairment on public interest grounds were not made in those circumstances. It therefore finds that Dr Webberley's fitness to practise is impaired on wider public interest grounds.

Paragraph 5(d)(iii)

161. The Tribunal noted that Dr Webberley does acknowledge her error in not discussing fertility with Patient C, and that she sought to address that by engaging with Patient C's mother in writing about the issue. It was, however, concerned that, in her reflective statement and in her evidence , she did not acknowledge that it behoved her to discuss this directly with Patient C, albeit in the sense of "starting the ball rolling", when she realised her error, and that this was the case notwithstanding that she had until late April 2017 (when she wrote the prescription) to do so, a period of five months from the date of the consultation. Indeed she does not say that it would now be her practice to discuss fertility even in this sense with all new patients. Moreover, the Tribunal was surprised by the fact that she omitted to discuss fertility with Patient C in the consultation as it is such an important aspect of transgender medicine.

162. The Tribunal noted Dr T's observations, quoted in its determination on facts, that there was a practical reason for discussing fertility as early as possible, namely preservation of fertility.

163. The Tribunal accepted that Dr Webberley recognises, particularly after the case of *Bell v. Tavistock*, that there will be cases when a transgender patient will regret a decision to change her gender, something which highlights the significance of the discussion on fertility.

164. The Tribunal accepted that Dr Webberley has an interest in the issue of fertility, particularly in relation to the issue of gamete storage, a matter which was the subject of published research by her in 2020 (in which she was the senior author) and of a conference which she attended in January 2020.

165. Nevertheless, the Tribunal did not consider that Dr Webberley has developed sufficient understanding as to the significance of how she failed Patient C in regard to discussing fertility, and as to how she can be sure that this will not be repeated. It therefore

determined that her fitness to practise is impaired by reason of her misconduct in failing to discuss the risks to Patient C's fertility with him on public protection grounds.

166. The Tribunal is fully aware that Patient C was being prescribed GnRHa - regarded as completely reversible - by Dr Webberley. It noted that the Endocrine Society Guideline recommends:

> *'We recommend that all transsexual individuals be informed and counseled regarding options for fertility prior to initiation of puberty suppression in adolescents and prior to treatment with sex hormones of the desired sex in both adolescents and adults.'*

167. However, the Guideline does not disclose the strength of the evidence on which that recommendation is based. Further the Tribunal noted that, in the section concerning the responsibilities of hormone prescribing physicians, WPATHSOC7 recommends a discussion concerning risks as follows:

> *'Discuss with patients the expected effects of feminizing/masculinizing medications and the possible adverse health effects. These effects can include a reduction in fertility (Feldman & Safer, 2009; Hembree et al., 2009). Therefore, reproductive options should be discussed with patients before starting hormone therapy (see section IX).'*

168. There is no corresponding recommendation in respect of GnRHa prescriptions. In these circumstances, the Tribunal does not consider that it is appropriate to find impairment of fitness to practise on public interest grounds alone.

Paragraph 5(i)(i)

169. The Tribunal acknowledges that its finding of misconduct in relation to paragraph 5(i)(i) concerns the referral by Dr Webberley of Patient C to Dr V and how she recorded her responses to Dr Pasterksi's report when it was received.

170. In her reflective statement, Dr Webberley stated:

> *'I also acknowledge that while it is very useful to have the email correspondence within the records as it gives such a clear written record of information gathered and shared, there should also to be a summary of each encounter as to what decisions were made and what actions were taken, as this could help future providers to understand the case history more easily.'*

171. The Tribunal has not been able to test whether Dr Webberley has implemented this approach as she has not been responsible for clinical care in GenderGP since April 2017. Nevertheless, it considers that she has recognised and accepted the Tribunal's view, and that therefore she has shown insight and a determination to address this deficiency in her record

keeping. It does not find that her fitness to practise is impaired by reason of her misconduct in this regard.

Paragraph 9(a) and (b)

172. The misconduct found proved in relation to Dr Webberley being unaware and never having seen the safeguarding policy relating to Dr Matt Limited represented a failure on her part to discharge her professional responsibility as Registered Manager and Safeguarding Lead. In short, she did not acquaint herself with or implement proper policies and procedures in relation to safeguarding required by CQC. Staff working for Dr Matt Limited should have had a policy which enabled them to deal with safeguarding issues which arose concerning their cohort of patients. They did not, other than Dr Webberley's statement that if there was a problem, they should come to her.

173. The Tribunal noted Dr Webberley's reflective statement in this regard:

> *'I fully respect the tribunal's findings that as a lead clinician in the Dr Matt service, I should have taken steps to ensure that there was a formal written policy in place. I understand that even though the service at that time was small with only a few team members working closely together, it was still important to make sure that documentation was in place that would stand up to scrutiny and be a reference point for staff.'*

174. The Tribunal is satisfied that Dr Webberley has comprehended her shortcomings in this regard. Whilst she is not presently a registered manager, she now recognises the steps which need to be taken if she were to assume professional responsibility for such a role again. The Tribunal did not regard this misconduct as so egregious as warranting a finding of impairment on public interest grounds alone. In short, the Tribunal does not find Dr Webberley's fitness to practise impaired by reason of her misconduct in this regard.

Paragraph 18

175. The Tribunal has marked Dr Webberley's behaviour in carrying out work for Frosts Pharmacy without informing them that she was suspended from the Medical Performers List with a finding of misconduct. It does not find that patients were, by her misconduct, put at unwarranted risk of harm, nor that by breaching her obligations in so transient a way, she has brought the profession into disrepute, nor that she had breached a fundamental tenet of the profession. It does not find that by reason of her misconduct in this regard, Dr Webberley's fitness to practise is impaired.

Paragraphs 28 and 29

176. The documents relied upon by the GMC in relation to the two paragraphs of the Allegation relate to Dr Webberley's conviction and sentence primarily concern her conviction. Indeed, the reasoning behind the District Judge's sentence of a fine of £12,000 on the first

count set out in paragraph 28(a) and no separate penalty on the second count set out in paragraph 28(b) is not before the Tribunal.

177. The Tribunal received advice from the LQC that it was entitled to take the circumstances surrounding a conviction into account when considering impairment, based on an analysis of ***R (on the Application of Jennifer Campbell) v. GMC [2005] EWCA Civ 250*** and ***GMC v. Bawa-Garba (BMA and others intervening) [2018] EWCA Civ 1879*** both in relation to impairment of fitness to practise and, if that stage is reached, sanction. It accepted that advice. However, it determined that it would not be appropriate, at the impairment stage of this inquiry, to take into account Dr Webberley's explanation as to why she continued to treat the clients and patients of online GP services limited whilst that company remained not registered by HIW.

178. The Tribunal noted that the two offences in respect of which Dr Webberley was found guilty were strict liability offences. That means that, if the Court found as a matter of fact that Dr Webberley did:

> *'a. carry on or manage an independent medical agency, namely Online GP Services Limited, without being registered under Part 11 of the Care Standards Act 2000;*
>
> *b. as a director of Online GP Services Limited, consent to that company carrying on or managing an independent medical agency, namely Online GP Services, without it being registered under Part 11 of the Care Standards Act, thereby committing an offence contrary to section 30(2) of the Care Standards Act 2000,'*

she would be guilty. Her mindset in relation to these matters would not be a relevant consideration for the Court.

179. The Tribunal is required to consider whether or not Dr Webberley's fitness to practise is impaired by reason of the convictions. It is therefore the fact of conviction which it is considering. There is no level of culpability in a strict liability offence.

180. In these circumstances, the Tribunal considered that the prudent and proper approach to considering whether Dr Webberley's fitness to practise is impaired by reason of the convictions is to limit itself to considering the circumstances whereby she came to be convicted. Those circumstances are a failure on her part to acquaint herself with the regulations under the Care Standards Act 2000 which required her to register her online medical agency with Health Inspectorate Wales. Ultimately it is not of any consequence that hers was the first conviction of its kind in Wales. At the material time she was an able and accomplished medical practitioner. She ought not to have plunged into developing an independent online agency without appropriate thought and reflection and preparation.

181. A conviction is a serious matter for a member of the medical profession.

182. The Tribunal finds that Dr Webberley's fitness to practise is impaired by reason of her conviction.

Determination on Sanction - 30/06/2022

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

Evidence

2. The Tribunal has taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction. It received no further evidence at this stage of the proceedings.

Submissions

For the GMC

3. Mr Simon Jackson QC submitted that the appropriate sanction in this case is a period of suspension. He acknowledged that the decision as to the appropriate sanction to impose is a matter for the Tribunal exercising its own judgment. He added that the Tribunal should start with the least restrictive sanction. He reminded the Tribunal of the need to take account of mitigating and aggravating factors, as well as any evidence of insight and remediation. He took the Tribunal through paragraphs of the Sanctions Guidance ('SG'), particularly paragraph 91, and also referred to relevant case law. Mr Jackson submitted that when considering the appropriate sanction, the Tribunal should be mindful of the duration and seriousness of the misconduct found and how far Dr Webberley's conduct had fallen below the expected standards.

4. Mr Jackson referred the Tribunal to its determination on impairment reminding it of its reasons for finding Dr Webberley's fitness to practise to be impaired, in relation to paragraphs 1(g)(i)(1, 2 and 3) and 3(h), 5(d)(iii), 28 and 29 of the Allegation.

In respect of paragraphs 1(g)(i)(1, 2 and 3) and 3(h)

5. Mr Jackson submitted Dr Webberley failed to recognise that the treatment she provided to Patients A and B carried significant risks for them if, for any reason, either did not communicate with her for further prescriptions. He said that it was wrong of Dr Webberley to not have in place a proper and reliable follow-up system and by not having one, she put Patients A and B at unwarranted risk of harm.

In respect of paragraph 5(d)(iii)

6. Mr Jackson submitted that Dr Webberley allowed some five months to pass, from the date of the consultation, before she discussed the matter of fertility with Patient C's mother. He reminded the Tribunal that, in her oral evidence at the impairment stage, Dr Webberley did not say that it would now be her practice to discuss fertility even in the sense of starting the ball rolling with all new patients.

In respect of paragraph paragraphs 28 and 29

7. Mr Jackson submitted that Dr Webberley, despite being advised by HIW to cease treating patients, continued to do so for some 11 months, before she stopped following her conviction. He told the Tribunal that the level of fine for this offence at the time was level 5 – unlimited. Previously it had been £5,000. The fine which was imposed was £12,000.

8. Mr Jackson reminded the Tribunal of the overarching objective which he said it must have regard to in the context of its findings on impairment, particularly when considering the matters relating to Dr Webberley's conviction and sentence.

9. In relation to insight and remediation, Mr Jackson submitted that Dr Webberley had failed to demonstrate to the Tribunal's satisfaction that she had developed insight into the concerns identified in this case and that she had remediated the misconduct. This, he said, was supported by the findings of the Tribunal in its determination on impairment.

10. Mr Jackson submitted that Dr Webberley's pattern of serious misconduct, combined with evidence of avoidance of regulation, give rise to a real risk of repetition in the future, with consequent serious risks to patient safety and that the profession will be brought into disrepute. Mr Jackson submitted that, in the light of Dr Webberley's lack of insight into her duties regarding registration, her incomplete remediation, and her overt efforts to avoid regulation, there remains a serious and obvious risk of repeated serious misconduct in the future. Mr Jackson invited the Tribunal to impose a period of suspension on Dr Webberley's registration.

For Dr Webberley

11. Mr Ian Stern QC referred the Tribunal to Dr Webberley's reflective statement of 4 June 2022. He took the Tribunal through its determination on impairment highlighting the factors which he submitted the Tribunal should take into account when considering the appropriate sanction. He addressed the Tribunal on those matters where it found Dr Webberley's fitness to practise impaired.

In relation to paragraphs 1(g)(i)(1, 2 and 3) and 3(h)

12. Mr Stern submitted that Dr Webberley set out in her reflective statement how, going forwards, she would proactively deal with new patients in terms of follow up. He reminded the Tribunal that it had found Dr Webberley's fitness to practise impaired in respect of these

paragraphs of the Allegation on public interest grounds only. He also reminded it of its finding that Dr Webberley had demonstrated insight and remediation in this regard, and that she posed no risk of repetition. Mr Stern stated that Dr Webberley has set out the steps she would initiate to ensure her patients were followed up, and that she would, at that point, review the patient before further prescribing any treatment. Mr Stern submitted that the public could be confident that Dr Webberley had and would continue to treat her patients appropriately.

13. Mr Stern said that the Tribunal should take into account that Dr Webberley had a *'heavy workload'* of patients, and that she was unable to identify or secure any further training to increase her understanding of and improve her practice. In light of this, Mr Stern submitted that Dr Webberley's failure in relation to paragraphs 1(g)(i)(1, 2 and 3) and 3(h) of the Allegation was isolated. Further, Mr Stern stated that there were no NICE guidelines which would have assisted Dr Webberley at the material time. He said that Dr Webberley did everything she could in the best interests of her patients but that does not mean she could not improve her clinical practice, as she has set out in her statement of 4 June 2022.

In relation to paragraph 5(d)(iii)

14. Mr Stern referred the Tribunal to his submissions at the facts stage in respect of this paragraph of the Allegation, and to paragraph 151 of its determination on impairment. He said that it was Dr Webberley's usual practice to discuss fertility with her patients at the initial consultation. He stated that this was evidenced in the note she wrote to Patient C's GP dated 26 February 2017, in which she acknowledged that, although fertility was mentioned, it was not discussed, and in the email to Patient C's mother. Mr Stern submitted it was clear this was an isolated omission on Dr Webberley's part, that she had addressed this in her statement of 4 June 2022, and that she was being open and transparent about this omission. He said that it was a regular feature in this case that most of the communications with the patients were done through their parents.

15. Mr Stern submitted that although the Tribunal found Dr Webberley's fitness to practise impaired on public protection grounds, the gravity of this was diminished for the reasons set out above. Mr Stern submitted that the public interest was in having a doctor who provided good care and treatment to her patients.

In relation to paragraphs 28 and 29

16. Mr Stern set out the background to the circumstances which led to Dr Webberley's conviction. He submitted that Dr Webberley was initially not aware of the requirement to be registered with HIW. He stated that from the point Dr Webberley was made aware of the requirement to be HIW registered, she took steps to get registered. Mr Stern reminded the Tribunal that Dr Webberley made it clear to HIW that she intended to continue to treat her existing patients as they had nowhere else to go to receive the treatment they required. He stated that as late as 24 April 2017, HIW had not decided whether Dr Webberley was breaking the law, as they conducted a PACE interview on that date. He submitted that this

demonstrated that HIW were themselves unsure over how to deal with Dr Webberley's case or how to respond to her representations about her patients having nowhere else to go.

17. Mr Stern said it had now been some four years since the conviction. He submitted that Dr Webberley has no previous adverse history with the GMC. He reminded the Tribunal it had found Dr Webberley to be a competent doctor in the area of gender dysphoria. He referred to relevant case law and took the Tribunal through the SG citing in particular paragraph 68 concerning taking no action. Mr Stern said that it cannot be ignored that Dr Webberley was an impressive doctor who had studied extensively in the field of gender dysphoria and who had gone to great lengths to provide good care and treatment to her patients. He submitted that the public would not only understand but respect Dr Webberley for the way she had acted. He added that it is hard to imagine what would have become of those patients if Dr Webberley had stopped treating them. He reminded the Tribunal of Patient A's evidence. He submitted that the approach Dr Webberley took in relation to treating patients whilst not registered was life-saving. She had probably prevented suicides and self-harming.

18. In concluding, Mr Stern submitted that this was an exceptional case. Dr Webberley provided treatment to patients not available elsewhere. Mr Stern said there was no need to send a deterrent message to the doctor. Mr Stern submitted it would not be right to impose a further period of suspension upon Dr Webberley's registration. He submitted, if anything, the public interest would be severely damaged by the imposition of conditions or suspension as this may restrict Dr Webberley from treating patients or engaging in research work. He referred the Tribunal to the testimonials received from various parties including parents of patients, and patients, all of whom speak very highly of her and her work. In respect of her requirement to register with HIW, he referred to the letters from Gender Identity Research and Education Society (GIRES) and UNIQUE in which grave concerns were expressed if Dr Webberley was forced to stop treating her then patient cohort. In all the circumstances, Mr Stern submitted that an order was not necessary and he invited the Tribunal to close the case with no action on Dr Webberley's registration.

The Tribunal's Approach

19. The decision as to the appropriate sanction, if any, to impose is a matter for the Tribunal alone, exercising its own judgement. In so doing, it has given consideration to its findings of fact, its findings of misconduct and impaired fitness to practise and the submissions made by both Counsel.

20. The Tribunal reminded itself of the statutory overarching objective, which it has set out in its determination on impairment, and that was at the forefront of its mind throughout this determination.

21. Throughout its deliberations on sanction the Tribunal bore in mind that the purpose of a sanction is not to be punitive, but to protect the public interest. The public interest includes protecting the health, safety and wellbeing of the public, maintaining public

confidence in the profession, and declaring and upholding proper standards of conduct and behaviour. In making its decision, the Tribunal also had regard to the principle of proportionality, and it considered Dr Webberley's interests as well as those of the public. It noted that this may include maintaining experienced clinicians in practice working for the public benefit in appropriate cases but the Tribunal has also to balance this with pursuit of the statutory over-arching objective.

The Tribunal's Determination on Sanction

22. The Tribunal's findings on impairment divide naturally into:

- those where limb one of the overarching objective is engaged – the protection and promotion of the health, safety and well being of the public, namely in respect of paragraph 5(d)(iii) of the Allegation; and

- those where limbs two and three of the overarching objective are engaged – the promotion and maintenance of public confidence in the medical profession and the promotion and maintenance of proper professional standards and conduct of the members of the profession, namely in respect of paragraphs 1(g)(i)(1, 2 and 3), 3h, 28 and 29 of the Allegation.

Fitness to practise history

23. The Tribunal noted that since Dr Webberley qualified in 1992, she has had an unblemished fitness to practise record.

References and testimonials

24. The Tribunal has considered the issue of sanction in the context of the references and testimonials which it has received concerning Dr Webberley. In particular, it has had regard to the references and testimonials contained in exhibit D28. This included 16 testimonials sent to the GMC from 13 parents, all of whom were aware of the allegations against Dr Webberley. They could not speak more highly of her. There were heartfelt expressions of gratitude, and observations that her work was life-saving.

25. It had regard to the letter dated 27 May 2017 to Mr KK, the Director of Inspection, Regulation and Investigation, HIW, from LL OBE, a trustee of GIRES who wrote:

> *'I am writing to express my deep concerns regarding the refusal to register Dr Webberley with respect to her service for transgender people. This leaves 2000 transgender, non-binary and non-gender people without care, despite the fact that the GMC has not seen it necessary to take this step.'*
>
> ….

26. It had regard to the letter from Ms NN OBE, the Chairperson of Unique Transgender Network, who wrote to Mr KK as aforesaid the following:

> ….
>
> *'I am writing to express my very grave concern regarding the refusal to register the GenderGP Service (Dr Webberley) for the support and clinical care of transgender / gender diverse people.'*
>
> ….

27. It had regard to the letter from Dr X, the Medical Director of the Center for Transyouth Health and Development at Children's Hospital Los Angeles, an internationally recognised expert in transgender medicine, dated 22 August 2019 who wrote in support of Dr Webberley in relation to her care of Patient A.

28. It also noted a letter to Dr Webberley from Dr Z dated 18 November 2016 concerning professional matters, in which he stated:

> *'….However, I think you are well on your way to developing a Beacon service in primary care for gender, as other GP services have done around the country in developing special interests in drug and alcohol treatments or managing common mental health disorders.'*

29. With these matters in mind, the Tribunal considered the issue of sanction in respect of each finding of impairment by reference to the relevant limb of the overarching objective.

<u>The Protection and Promotion of the Health, Safety and Well-Being of the public</u>

Paragraph 5(d)(iii) of the Allegation

30. The relevant finding of the Tribunal in respect of impairment is paragraph 165 which reads:

> *'165. Nevertheless, the Tribunal did not consider that Dr Webberley has developed sufficient understanding as to the significance of how she failed Patient C in regard to discussing fertility, and as to how she can be sure that this will not be repeated. It therefore determined that her fitness to practise is impaired by reason of her misconduct in failing to discuss the risks to Patient C's fertility with him on public protection grounds.'*

31. Of course the Tribunal's finding relates to the precise language of the paragraph of the Allegation. That identifies that the discussion should have taken place before treatment commenced. There are a number of points which, in the Tribunal's view, add context to the failure which the Tribunal found proved, as follows:

- Issues relating to the treatment of gender dysphoria, including the risks to fertility, are on-going and warrant continuing discussion;
- The Tribunal was concerned that Dr Webberley did not "start the ball rolling" by engaging in discussion with Patient C about the risks to his fertility before commencing treatment. That contemplates that the ball will continue to roll after commencement of treatment;
- Fertility was mentioned at the consultation but there was no ensuing discussion;
- Dr Webberley recognised her omission herself contemporaneously, without stimulus from a third party. Indeed, she disclosed it in her letter to Patient C's GP;
- Dr Webberley recognised this as an error in her reflective statement;
- Dr Webberley sought to correct that error contemporaneously by engaging extensively with Patient C's mother in writing;
- Patient C was aged 10 years and 8 months when she consulted with him on the telephone and 10 years and 9 months when she was saw him face -to-face in December 2016. A discussion on the telephone and/or face-to-face with Patient C when he was that age would certainly have involved significant input from Patient C's mother;
- Dr Webberley was reassured in her correspondence with Patient C's mother.

32. Notwithstanding these points, which the Tribunal consider diminish the seriousness of the finding of impairment, the Tribunal found serious misconduct and that Dr Webberley's fitness to practise is impaired by her lack of insight. In the Tribunal's view that finding means that it would not be appropriate to close this case with no action. Dr Webberley needs to demonstrate to a Medical Practitioner's Tribunal that she has developed the necessary insight and remediation to enable it to conclude that there is no risk of repetition.

33. The Tribunal concluded that the misconduct found is remediable. The Tribunal is satisfied that Dr Webberley should be allowed an opportunity to demonstrate whether she has achieved the necessary insight and that she has remediated her shortcomings. That will enable her to return to unrestricted practise. The Tribunal recognises that it should only impose the least restrictive sanction consistent with its duty, in this instance, to protect the public. However, it does not consider that an order of conditions is an appropriate sanction in the circumstances of this case. It finds that the appropriate sanction for this aspect of the Tribunal's finding of impairment is a period of suspension. The Tribunal's final decision on sanction is, of course, subject to its determination in respect of the other aspects of impairment found in this case.

The Promotion and Maintenance of Public Confidence in the Medical Profession and the Promotion and Maintenance of Proper Professional Standards and Conduct of the Members of the Profession

34. As mentioned, two findings of impairment fall to be considered in respect of the second and third limbs of the overarching objective.

Paragraph 1(g)(i)1, 2 and 3 and Paragraph 3(h) of the Allegation

35. The relevant finding in respect of impairment is paragraph 160 which reads:

The Tribunal considered whether it should make a finding of impairment based upon the public interest alone. Having regard to Dame Janet Smith's categorisation of cases which may lead to a finding of impairment, the Tribunal has found that Dr Webberley's misconduct in this regard did put Patients A and B at unwarranted risk of harm. In the Tribunal's view an informed member of the public would be surprised if a finding of impairment on public interest grounds were not made in those circumstances. It therefore finds that Dr Webberley's fitness to practise is impaired on wider public interest grounds.

36. These paragraphs of the Allegation concern Dr Webberley's failure to provide adequate follow up care to Patients A and B after initiating testosterone treatment.

37. The Tribunal considered that there were no aggravating factors which it ought to take into account. Dr Webberley's failures are encapsulated in the paragraphs of the Allegation found proved. Whilst it noted that there was no evidence that she expressed apology to Patient B and/or his mother, there was no evidence that she had any opportunity to do so. Her failure to arrange review consultations for Patient B reflected her then approach to providing follow up care. By contrast there was much evidence that she apologised and showed contrition towards Patient A and his mother. That evidence was recited in the Tribunal's determination on facts.

38. The Tribunal considered that the following were mitigating factors particularly germane to the misconduct found proved:

- Dr Webberley showed remorse and contrition to Patient A and his mother as mentioned;
- Dr Webberley has developed insight into her failings and demonstrated remediation to the Tribunal's satisfaction;
- These matters occurred over five years ago.

Paragraphs 28 and 29 of the Allegation

39. The relevant finding in respect of impairment is set out in paragraphs 180 to 182 which read:

180. In these circumstances, the Tribunal considered that the prudent and proper approach to considering whether Dr Webberley's fitness to practise is impaired by reason of the convictions is to limit itself to considering the circumstances whereby she came to be convicted. Those circumstances are a failure on her part to acquaint herself with the regulations under the Care Standards Act 2000 which required her to register her online medical agency with Health Inspectorate Wales. Ultimately it is not

of any consequence that hers was the first conviction of its kind in Wales. At the material time she was an able and accomplished medical practitioner. She ought not to have plunged into developing an independent online agency without appropriate thought and reflection and preparation.

181. A conviction is a serious matter for a member of the medical profession.

182. The Tribunal finds that Dr Webberley's fitness to practise is impaired by reason of her conviction.

40. The Tribunal considered there were no aggravating factors which it ought to take into account. As mentioned, the fact of any conviction is a serious matter for a member of the medical profession.

41. The Tribunal considered that there were mitigating factors as follows:

- Once Dr Webberley was made aware that registration was required for her company to provide online services, she engaged with HIW, including the instructing of solicitors to negotiate a resolution of the concerns raised;
- When her solicitors engaged with HIW, they made it clear that she was currently providing medical treatment. The request was made that she should be allowed to continue her work pending the appropriate application being made;
- When the HIW responded, Dr Webberley was not told that she should cease all treatment. She was asked not take any new patients. Dr Webberley complied with that request. HIW were aware that she was continuing to treat existing patients;
- When on 24 March 2017, HIW requested confirmation that no services would be provided until registration, Dr Webberley was in a very difficult position. Her cohort of patients, who numbered up to 2,000, according to the letter from GIRES, had nowhere else to go. Dr MM CBE, the Chair, BMA General Practitioners Committee had written to Professor TT, the Chair of Council, GMC on 12 May 2016 expressing concerns about GPs assuming a role of prescribers in the context of transgender healthcare, which for most GPs was unfamiliar territory. Even if GPs were prepared to issue bridging prescriptions, that would not deliver long term treatment. These patients were an extremely vulnerable group who had turned to Dr Webberley since they were unable to receive treatment from GIDS on the NHS. A measure of their vulnerability is the lengths to which they had gone to obtain that treatment which was offered privately. Patient A's mother explained in her evidence that she took a second job to enable her to afford private treatment from Dr Webberley.
- Dr Webberley asked to speak to the Medical Adviser of HIW to explain the position. This was declined;
- When Dr Webberley continued to treat patients, it was not clear, even to HIW, that she required registration or that she would be prosecuted for not being registered.

- The conviction was three and a half years ago. It was in respect of matters which occurred four to five years ago.

42. Further in relation to both these wider public interest matters relating to the second and third limbs of the overarching objective, the Tribunal considered that the following matters also constitute mitigation:

- Dr Webberley has no previous fitness to practise history;
- Dr Webberley's registration was made subject to interim conditions in May 2017 which effectively prohibited her from working as she could not obtain a supervisor for her adolescent transgender work. She was made the subject of an Interim Suspension Order on 26 November 2018 which remained in position until 2 February 2022 when it was replaced by the less restrictive measure of a further Interim Conditions of Practice Order. Effectively she has not been able to work for in excess of 5 years.

43. The Tribunal has reached the conclusion that it would be appropriate to close both cases which relate to the promotion and maintenance of public confidence in the medical profession and proper professional standards and conduct of the members of the profession with no action. There are in the view of the Tribunal exceptional circumstances justifying that decision as follows:

- The finding of impairment in respect of Dr Webberley's misconduct in failing to provide adequate follow up care is a sufficient mark of the Tribunal's concern in the context of her having understood and remedied her failings in this regard;
- The conviction is sufficient to mark Dr Webberley's failure to obtain registration;
- There were factors which reduced her level of culpability in relation to her continuing to treat patients while Online GP Services Limited was not registered as set out above in relation to the conviction;
- Dr Webberley has had her registration restricted on an interim basis for an inordinately long period. Not only has this prevented Dr Webberley from practising medicine, it limited her ability to engage in wider professional activities, such as speaking at conferences, as invitations to speak were withdrawn. It would be thoroughly disproportionate to extend that period any further on these grounds;
- There are no public protection arguments which apply to these aspects of the Tribunal's findings of impairment.

44. The Tribunal, therefore, finds that a suspension order on Dr Webberley's registration to address the impairment found on public protection grounds arising from paragraph 5(d)(iii) of the Allegation is the appropriate sanction in this case.

45. In determining the length of the suspension, the Tribunal considered whether it should take into account the interim orders imposed upon Dr Webberley's registration prior to these proceedings. It concluded that it should not do so. The period of suspension which

the Tribunal considers it should impose is that period which allows Dr Webberley the opportunity to demonstrate her level of insight into this aspect of the Tribunal's finding of impairment. The Tribunal has determined therefore to suspend Dr Webberley's registration for a period of two months. The Tribunal considered that this period will allow Dr Webberley sufficient time to demonstrate whether she has the necessary insight into the concerns identified by this Tribunal and that she has remediated her shortcomings. It is also the shortest practical period to make arrangements for a review hearing to take place.

Review

46. The Tribunal directs that before the end of the period of suspension, Dr Webberley's case be reviewed by a Medical Practitioners Tribunal. A letter will be sent to her about the arrangements for the review hearing. The Tribunal considered that the reviewing Tribunal would be assisted by receiving the following:

- A reflective statement from Dr Webberley setting out her understanding of how she failed Patient C by not discussing with him the risks to his fertility before prescribing GnRHa treatment and how she will avoid repeating that mistake in future cases of a like nature.

Determination on Immediate Order - 30/06/2022

1. Having determined to suspend Dr Webberley's registration, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether her registration should be subject to an immediate order.

Submissions

For the GMC

2. Mr Simon Jackson QC referred the Tribunal to paragraphs 172 - 178 of the SG. He also referred the Tribunal to paragraphs 30, 32, 44, 45 and 46 of its determination on sanction. He submitted that if an immediate order were not in place, and Dr Webberley were to appeal the decision of the Tribunal, she would be entitled to continue to work until the outcome of such appeal was known.

3. He said that if Dr Webberley were to return to clinical practice in this area of medicine, and if faced with similar pressures, for example a heavy workload and requests from patients for treatment, there was no way of managing any risk of repetition. In consequence, he submitted that it was necessary for the protection of the public to impose an immediate order of suspension.

For Dr Webberley

4. On behalf of Dr Webberley, Mr Stern QC opposed the GMC application for an immediate order. He said that the starting point was to consider the purpose of an immediate order. Mr Stern said the effect of any immediate order would be disproportionate because if Dr Webberley were to appeal, an immediate order would remove her ability to secure suitable employment until such time as the outcome of the appeal was known.

5. Mr Stern submitted that the Tribunal had no right to impose an immediate order in this case on any wider public interest grounds as the Tribunal had not imposed any substantive sanction in respect of those findings of impairment which concerned the wider public interest.

6. Mr Stern submitted that an immediate order was not necessary for the protection of the public in respect of Dr Webberley's failure to discuss fertility with Patient C prior to treatment. He relied upon the factors to which the Tribunal referred in paragraph 31 of its determination on sanction.

The Tribunal's Determination

7. The Tribunal has taken account of Section 38 of the Medical Act 1983 and the relevant paragraphs of the SG in relation to when it is appropriate to impose an immediate order. Paragraph 172 of the SG states:

> *'The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor…'*

8. The Tribunal reminded itself of its finding in paragraph 32 of its determination on sanction that Dr Webberley needs to demonstrate to an MPT that she has the necessary insight and remediation to enable it to conclude that there is no risk of repetition. In these circumstances, it has determined that it is necessary for the protection the public to make an immediate order of suspension.

9. The substantive order of suspension, as already announced, will take effect 28 days from when notice is deemed to have been served upon Dr Webberley, unless she lodges an appeal in the interim. If she lodges an appeal, the immediate order of suspension will remain in place until such time the outcome of the appeal is known.

10. The Tribunal has revoked the interim order on Dr Webberley's registration.

11. That concludes the case.

ANNEX A – 27/07/2021 - Rule 34(1) Application to admit hearsay evidence

Submissions on behalf of Dr Webberley

1. On 26 July 2021 (Day 1), Mr Ian Stern QC, on behalf of Dr Webberley, made an application for a number of documents contained within the Defence bundle (the relevant documents having been redacted at this stage) to be admitted into evidence. Mr Stern set out the chronology of correspondence between the GMC and Dr Webberley's legal representatives, together with the chronology of the discussions held between Dr Webberley's legal representatives and the GMC and the MPTS Case Management Team. Mr Stern told the Tribunal that the Defence bundle was finalised on 13 July 2021 and was provided to the GMC on 14 July 2021. On 15 July 2021, Dr Webberley's legal representatives received an email from the GMC in which the GMC raised objections to parts of the defence bundle.

2. Mr Stern said that the GMC objected to the following pages being included in the defence bundle:

19 – 31;
343 – 511;
516 – 738;
833 – 971.

3. Mr Stern referred the Tribunal to Rule 34(1) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'). He stated that the basis for the GMC's objection appeared to be two-fold: first, that the documents in the defence bundle on the page numbers set out above amount to testimonial evidence which does not go to the charges of dishonesty, and are only relevant at stage 2 of these proceedings, should that stage be reached; secondly, the statement of Patient A's mother and the documents relied upon by her, the letter from Dr V, a psychologist referred to in the defence bundle, and the report from a gender specialist, Dr X dealing with Patient A constitute hearsay evidence which ought not to be admitted unless the authors of those documents are to be called to give evidence.

4. Mr Stern advanced his argument stating that the documents which had originally been included as part of the defence bundle were Dr Webberley's exhibits to her witness statement for the purposes of earlier proceedings relating to these matters. He said that the documents contained letters from a number of transgender organisations who had expressed their opinion as to the care and treatment provided by Dr Webberley to the patients in this case. He added that the redacted pages 343-511 contained documents relevant to these proceedings because they were relied upon by the GMC's experts to write their reports. Mr Stern said that none of these documents, particularly pages 516-738, should be described as testimonials. Mr Stern submitted that the documents should be placed before the Tribunal as they go to the issues around the alleged dishonesty and, were relevant

to these proceedings. Mr Stern referred the Tribunal to the principles set out in a number of authorities which he said were relevant and supported his application, including R (Bonhoeffer) v GMC [2011] EWHC 1585 (Admin), El Karout 2019 EWHC 28 (Admin), and Thorneycroft 2014 EWHC 1565 (Admin). Mr Stern invited the Tribunal to admit the pages set out above. In concluding, Mr Stern told the Tribunal that it is likely that the mother of Patient A, and one of the experts, Dr V would be called as witnesses.

Submissions for the GMC

5. Mr Simon Jackson QC submitted that the pages referenced above should not be admitted. He too referred the Tribunal to the principles set out in various authorities, including R (Bonhoeffer) v GMC [2011] EWHC 1585 (Admin), NMC v Ogbonna [2010] EWCA Civ 1216, El Karout 2019 EWHC 28 (Admin) and Khan v General Medical Council [2021] EWHC 374 (Admin). He said that there was concern over the provenance of these documents and it could not be right that the opinions or views of individuals, who are unable to give a qualified opinion about the care and treatment provided by Dr Webberley to the patients in this case, are admitted.

6. Mr Jackson submitted that the GMC would wish to cross-examine the individuals referred to in pages 19 - 31, adding that pages 28 - 31 only include correspondence between Dr Webberley and two hospital consultants about her clinical practice and that the GMC would prefer to hear from and cross examine the two consultants mentioned.

7. In relation to pages 343 – 511, Mr Jackson submitted that these pages contained correspondence from unidentified transgender patients and the documents have been exhibited as part of a witness statement previously prepared by Dr Webberley. Mr Jackson said that there was no provenance to this correspondence or any qualification of it, and the documents were incapable of being checked or tested as part of any cross-examination.

8. In relation to pages 516 – 738, Mr Jackson submitted that the reasons for objecting to these documents being placed before the Tribunal are the same as for pages 343 – 511.

9. Mr Jackson then summarised the contents of the documents contained within pages 833 – 971. He told the Tribunal these included letters of support and endorsement for Dr Webberley's clinical practice but stated that the provenance of these documents was unknown and could not be tested. In relation to a letter from Dr V, Mr Jackson submitted that if Dr V were to be called as a witness, his expert opinion could be tested in cross examination, and therefore, the GMC would withdraw its objection to the documents relevant to his evidence being placed before the Tribunal.

10. Mr Jackson went on to say that the document contained at pages 884-890 was a letter or an expert report, dated 22 August 2019, and addressed 'To whom it may concern'. Mr Jackson said that the author is Dr X MD, Medical Director, at the Center for Transyouth Health and Development, Children's Hospital, Los Angeles, USA. Mr Jackson said that as Dr X

is no longer attending these proceedings to give evidence, her evidence cannot be tested by cross examination.

11. In relation to pages 892-894, Mr Jackson said that although this letter of support is from an identified person, it was addressed to a Complainant Organisation, and its provenance in these proceedings was not made out. Therefore, the GMC would wish to cross-examine the evidence of the individual.

12. Mr Jackson added that the same reasons for objecting apply to the documents contained at pages 897-971, which are letters of Support from identified individuals. In the circumstances, Mr Jackson submitted that the documents referenced by the page numbers set out above should not be admitted.

The Relevant Legal Principles

13. The Tribunal accepted the Legally Qualified Chair's advice and had regard to the allegation before it and was mindful of the provisions of Rule 34. This states:

> *"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."*

14. He summarised the principles which the Tribunal should consider having regard to Rule 34(1) and the cases of ***Bonhoeffer, Ogbonna, El Karout 2019 EWHC 28 (Admin)*** and ***Thorneycroft 2014 EWHC 1565 (Admin)***.

15. In summary these cases provide:

- The admissibility of evidence is subject to Rule 34 of the Rules which reflect the general common law requirements of relevance and fairness;
- What is fair is fact sensitive and will depend on the circumstances in an individual case, particularly the nature and subject matter of the proceedings (***Bonhoeffer, Ogbanna***);
- In deciding whether or not to admit hearsay evidence, a committee is entitled to take into account the fact that it can give less weight to the evidence than if the maker of the statement was available to be cross-examined (***Thorneycroft***);
- The existence of a good and cogent reason for the non-attendance of the witness is an important factor. However, the absence of a good reason will not automatically result in the exclusion of the evidence (***Thorneycroft***);
- The courts have been reluctant to uphold decisions to admit hearsay evidence where the hearsay evidence in question was the sole or decisive evidence in relation to an allegation (***Bonhoeffer, Ogbonna***);
- Character evidence relating to propensity, called by the defence, is admissible in principle, but it is normally limited to evidence of good character. The legitimate purpose is to enable a Court or a Tribunal to take into account that the accused does

not normally act in the way alleged by the prosecution which amounts to bad character;
- Tribunals should properly analyse the admissibility and weight of hearsay evidence when considering whether it is fair to admit such evidence (***El Karout***);
- Tribunals should adopt a careful balancing exercise when considering hearsay evidence, especially where it is key evidence for a particular allegation (***El Karout***).

16. The Tribunal throughout also had regard to the public interest as set out in the overarching objective in section 1(1A) of the Medical Act 1983.

Tribunal's decision

17. The Tribunal was mindful of the submissions made by both Counsel: Dr Webberley wished for these documents to be included while the GMC objected. The GMC's objection was based on relevance and / or fairness, the two matters under Rule 34 of the GMC Rules 2004 which govern the admissibility of evidence in fitness to practise hearings. The Tribunal determined these matters in the absence of any witness statements being served and / or disclosed to the Tribunal on the part of Dr Webberley, including from herself, save for two witness statements from her which were relied on by her in interim order proceedings, which were included in her bundle, one of which was heavily redacted. The absence of any witness statement on fitness practise issues from Dr Webberley at this stage of the case made the task of the Tribunal a difficult one; the context of the disputed evidence has been difficult to discern. Nevertheless, the Tribunal has reached a decision as to the admissibility of this documentation. It is possible that this decision should be reviewed as the case unfolds, but the Tribunal hope that it will serve to allow the Case Presenter to open the case when pleas have been taken in respect of the several paragraphs of the Allegation which Dr Webberley faces.

Pages 343 to 511 and 516 to 688

18. According to her second witness statement in the interim order proceedings, these documents are a selection of self-referral emails which Dr Webberley has received which highlight the reasons why patients and the public have referred themselves to her. They are not from any of the patients whose cases are the subject of the Allegation. Effectively they go to the value of the service which she runs for persons who are awaiting NHS Gender identity clinics. The Tribunal recognise that this material is important to Dr Webberley, and may be so at a later stage of the hearing, but it does not consider it goes to any issue raised in any of the paragraphs of the allegation. If anything, it goes to the propensity of Dr Webberley to treat patients professionally and responsibly. Evidence of propensity is normally adduced by the Defence by way of character evidence to enable a court or tribunal to take into account character when determining allegations which might be said to amount to bad character, such as dishonesty or sexual misbehaviour. The Tribunal does not consider that propensity evidence is admissible to show that Dr Webberley normally treats patients professionally and responsibly. The issue in this case is whether she did so in respect of the patients named in the Allegation. The Tribunal rules that this material is not admissible at this stage.

Pages 833 to 844 and 19-23

19. This includes a witness statement from Patient A obtained by the GMC and a letter sent by the witness to the GMC about the service her son received at the NHS and through Dr Webberley as well as a further letter to the GMC complaining about Professor F. Mr Stern on behalf of Dr Webberley has indicated that he is intending to serve a witness statement from Patient A's mother. The Tribunal has determined that these documents are relevant and that it is fair to admit them.

Pages 24-27

20. This is a statement from the mother of a transgender child who describes her experience in the NHS with regard to her son and the experience with Dr Webberley. For the same reasons as set out in respect of pages 343 to 511 and 516 to 688, the Tribunal does not consider that it goes to any issue raised in any paragraphs of the Allegation. The Tribunal rules that this material is not admissible at this stage.

Page 28

21. This is an email by Dr Webberley to a cardiologist and his response in relation to a transgender patient. So far as the Tribunal understands, this does not refer to any of the patients named in the Allegation. For the same reasons as set out in respect of pages 343 to 511 and 516 to 688, the Tribunal does not consider that it goes to any issue raised in any paragraphs of the allegation. The Tribunal rules that this material is not admissible at this stage.

Pages 29 to 31

22. This is a letter from a Consultant Neuropsychiatrist at the Gender Clinic in Daventry dated 18th November 2016. The letter is not a testimonial but follows a visit by Dr Webberley to the Gender Clinic and is a 'thank you' and detailed letter regarding the meeting they had as professional colleagues and the matters they discussed and what they might discuss in the future. The Tribunal understands that this letter is not about Patient C nor any of the patients named in the Allegation. For the same reasons as set out in respect of pages 343 to 511 and 516 to 688, the Tribunal does not consider that it goes to any issue raised in any paragraphs of the allegation. The Tribunal rule that this material is not admissible at this stage.

Pages 881 to 883

23. This is a letter from the gender identity specialist Dr V (whose report regarding Patient C is in the records for that patient). The letter came as a result of a request by the GMC and is dated 23rd November 2017. It deals with her contact and discussions with HW. The Tribunal understands that Dr Webberley intends to call Dr V as a witness. The Tribunal has determined that these documents are relevant and that it is fair to admit them.

<u>Pages 884 to 890</u>

24. This is a report on Dr Webberley's care of Patient A, dated 22nd August 2019. The Tribunal understands that this report was passed on to Dr S by the GMC in the preparation of his report. The Tribunal assumes that the report is signed. The author of this report has explained why she will not attend the hearing. In an email dated 3 June 2021 the author of the report writes:

> *'I have had a series of violent threats to my life that have intensified over the past week that have necessitated me having personal security at my home, and my hospital is not keen on me participating in these kinds of cases right now.'*

25. The name of the author of the report is clearly known to the GMC – the GMC was sent the report. The Tribunal accepts that there are good reasons for Dr Webberley not being in a position to call the author to give evidence either in person or remotely. It is also the case that the Defence will be in a position to cross examine Dr S about the contents of this report. Although it does not appear to be a final report, the circumstances are such that the Tribunal has determined that it is fair to admit them.

<u>Pages 729 to 733</u>

26. These are emails in November 2016 to January 2017 between the GMC and Dr Webberley regarding their discussions on transgender patients and developing learning materials for doctors in this regard. This material reflects the fact that the GMC engaged Dr Webberley to assist it in developing learning materials and training. In view of the paragraphs which allege that Dr Webberley was acting outside her competence, the Tribunal has determined to admit this documentation which appears on the face of it to go to an endorsement of her competence by the GMC in the past.

<u>Pages 689-711; 716-719; 906-912; 918-933; 961-966</u>

27. According to her second witness statement in the interim order proceedings, these are letters of support for Dr Webberley written to the GMC from patients or parents of patients following public knowledge of the GMC investigation. For the same reasons as set out in respect of pages 343 to 511 and 516 to 688, the Tribunal does not consider that it goes to any issue raised in any paragraphs of the allegation. The Tribunal rules that this material is not admissible at this stage.

<u>Pages 712-714; 715; 720-724; 902-903</u>

28. According to her second witness statement in the interim order proceedings, these are letters of support from transgender organisations (Gires; Mermaids; Unique transgender network (largest transgender group in Wales); Transfigurations). For the same reasons as set out in respect of pages 343 to 511 and 516 to 688, the Tribunal does not consider that it goes

to any issue raised in any paragraphs of the allegation. The Tribunal rules that this material is not admissible at this stage.

ANNEX B – 27/07/2021 - Application to Amend the Allegation

1. On 27 July 2021 (Day 2), Mr Jackson QC, on behalf of the GMC, made an application to amend the Allegation to amend the stem of paragraphs 1b, 3b and 5a to include the word 'adequately' before the word 'examined' in the context of Dr Webberley arranging for the examination of Patients A, B & C, so that they read as follows:

> '1b. arrange for Patient A to be <u>adequately</u> examined prior to prescribing testosterone treatment, including:'
>
> 3b. arrange for Patient B to be <u>adequately</u> examined prior to prescribing testosterone treatment, including:'
>
> '5a. did not arrange for Patient C to be <u>adequately</u> examined prior to prescribing testosterone and GnHRA treatment, including:'

2. Mr Jackson explained that these amendments are sought following a careful review of the expert evidence and, in particular the report of Dr Q, dated the 16 March 2021.

3. Referring to paragraph 5a(ii) of the Allegation, Mr Jackson stated that whilst Dr Webberley did arrange for a psychological assessment, this was not an adequate assessment.

4. Mr Jackson drew the Tribunal's attention to paragraph 15 of Good Medical Practice ('GMP'). These state:

> *'15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*
>
> *a. adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
>
> *b. promptly provide or arrange suitable advice, investigations or treatment where necessary*
>
> *c. refer a patient to another practitioner when this serves the patient's needs.'*

5. Mr Jackson submitted that the proposed amendments were to reflect the standard of care expected of doctors to patients, as set out in GMP, and nothing more. He added that Dr Webberley has had notice of the implicit allegation since the service of Dr Q's report upon her and her legal representatives. He submitted that no prejudice would be caused to Dr Webberley as a result of the proposed amendments; there is no expert evidence which suggests that a standard lower than 'adequate' was acceptable; and that, in any event, Dr V could deal with this issue in relation to Patient C.

6. Mr Jackson said that the amendments to allegations 1b(ii) (Patient A) & 3b(ii) (Patient B) are sought to ensure consistency with allegation 5a, as amended (Patient C).

7. Mr Jackson added that in relation to the discrepancy in the date in paragraph 3 of the Allegation, this could be addressed by amending the stem of paragraph 3 so that it reads 'Following an initial consultation with Patient B on or about 10'. Mr Jackson went on to state, in relation to paragraphs 1a and 3a, that the amendment is sought because paragraphs 1a and 3a deal with the physical examination, whereas paragraphs 1b and 3b are concerned with the psychological assessment, which was not undertaken in this case.

8. Mr Stern QC opposed the application. He said that the GMC has had all the documentation, including the report of Dr Q, for some time**.**

9. In relation to paragraphs 1b, 3b and 5a, Mr Stern stated that there have been a number of versions of the Allegation and the GMC has had ample opportunity to amend the Allegation. He said that the Notice of Hearing was issued to Dr Webberley on 21 June 2021, and to propose any amendments at this stage is unfair, particularly where the proposed amendment widens the allegation rather than narrows it. Mr Stern added that there is no new evidence to support the amendments proposed.

10. Mr Stern directed the Tribunal to Dr Q's report stating that Dr Q was clear that the psychologist in their report considered the examinations to be thorough and appropriate in relation to the issue of gender dysphoria. Mr Stern submitted that, in light of the information before the Tribunal, it is not clear on what basis the proposed amendments should be made, and to amend the particulars of the Allegation as suggested by the GMC would be to introduce new allegations.

11. Mr Stern went on to say that if the Tribunal were to allow the application, then this would suggest that the GMC can and would make 'last minute' changes to the Allegation. He said that this was an 'absurd way' of proceeding with the allegations. Mr Stern invited the Tribunal to refuse the GMC's application.

Tribunal's decision

12. The Tribunal had regard to Rule 17(6) 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."*

13. The Tribunal noted the submissions by both Counsel. It considered the basis of the GMC's application to amend paragraphs 1(b), 3(b) and noted that the allegation in paragraph 5(a) is already particularised as follows:

> '5. Following an initial consultation with Patient C on 9 November 2016 you failed to provide good clinical care in that you:
>
> a. did not arrange for Patient C to be examined prior to prescribing testosterone and GnHRA treatment, including:
>
> i. a physical examination to determine:
>
> 1. bone health;
> 2. height;
> 3. weight;
> 4. blood pressure;
> 5. Tanner staging of Patient C's pubertal development, including stages of:
>   i. pubic hair growth;
>   ii. breast development;
>
> ii. full psychological pre-diagnostic input to:
> 1. clarify diagnoses;
> 2. explore additional factors, including Attention Deficit Hyperactivity Disorder;'

14. The purpose of further particularisation therefore is questionable since the word adequately is unlikely to add anything further to the allegation. The provenance of the allegation appears to stem from Dr Q's report in relation to Dr Webberley's care of Patient C wherein he states, in relation to the question:

> "Please outline the psychology input for this patient",:
>
> *'Patient C received a diagnostic assessment from* [Dr V] *(counselling psychologist)* [Dr V] *prior to being accepted to Gender GP services. There was no psychology input from* [Dr V] *following the initial assessment.*
> *The psychology input did not fully explore differential/co-morbid diagnoses (e.g. ADHD) indicated by [Patient C]'s mother's developmental history and background in in-utero exposure to heroine. Screening measures or multidisciplinary assessment should have been used to ascertain the need for further investigation. No referral was made to explore a diagnosis of ADHD. This is of concern because this may have impacted on formulation, treatment and ongoing management.*

- *There was a failure to provide the full psychological pre-diagnostic input recommended by WPATH and the NHS service specifications around clarifying diagnoses.*
- *The assessment provided by* [Dr V] *was thorough and informed well by her expertise in gender dysphoria, however as an initial psychological assessment it lacked breadth and did not fully explore additional factors such as ADHD.*
- *This is an inadequate standard of assessment.'*

15. The Tribunal was of the view that the matters set out in Dr Q's report were adequately reflected in the allegation without amendment. It therefore turned to consider the application to amend in respect of paragraphs 1(b) and 3(b) of the Allegation. Those paragraphs read as follows:

'1 Following an initial consultation with Patient A on 22 March 2016, you failed to provide good clinical care in that you did not:

a. …;

b. arrange for Patient A to be examined prior to prescribing testosterone treatment, including:

i. a physical examination to determine:
1. blood pressure;
2. weight development;
3. final height assessment;
4. bone health;
5. an assessment to ensure a synchronised pubertal development with peers;

ii. a psychological assessment to confirm a diagnosis of gender dysphoria;'

and

'3 Following an initial consultation with Patient B on 11 August 2016, you failed to provide good clinical care in that you did not:

a. …;

b. arrange for Patient B to be examined prior to prescribing testosterone treatment, including:

i. a physical examination to determine:
1. blood pressure;
2. weight development;

ii. a psychological assessment to:
1. confirm a diagnosis of gender dysphoria;
2. consider alternative diagnoses;
3. determine Patient B's mental health needs;'

16. Unlike the situation addressed by paragraph 5(a) of the Allegation, Dr Webberley had not arranged any psychological assessment of Patient A and Patient B. Dr Q has addressed this in his reports.

17. In respect of Patient A he opined:

> *'I can see no evidence of psychological input from a mental health professional via Dr Webberley at GenderGP. This is of concern as in a letter dated 7th March 2017 Dr Webberley reports to [Patient A]'s GP:*
>
> > *'[Patient A's] behaviour and mental state have been in serious decline BLANK and the family have not known how to cope with it. [Patient A] and the family all feel that it is due to the withdrawal of testosterone and the puberty that it was allowing [patient A] to have in line with his peers, and this has caused this massive deterioration in his mental health. BLANK describes feeling that she feared for [Patient A's] life in terms of self-harm and suicide and that at that time she herself would not be able to cope with the thought of losing a child and it was almost worth pre-empting that horrific situation.'*
>
> *Whilst there was a medical understanding of the causes for this deterioration in mental health (due to testosterone withdrawal), there is no mention of referral to a psychological or mental health practitioner to fully assess and confirm this or the risk associated with the deterioration. It is conceivable that given the trigger for this episode was cessation of testosterone recommended by the Tavistock GIDS, that Dr Webberley reasonably assumed that they would be taking responsibility for the effect of their recommendation to cease the medication on [Patient A]'s mental state as would be their (shared) duty of care. Were this the case it would have been proper to communicate with all concerned agencies and clinicians and develop a management plan. I cannot see evidence of any co-ordination over the management of this issue between the Tavistock clinic, UCLH GIDS and GenderGP.*
>
> *• There was a failure to include psychological input for this patient when their mental health deteriorated in response to a recommended medication change. This is of concern as testosterone medication did not appear to be being reinstated at any time in the near future and [Patient A]'s psychological state remained unaddressed. There were concerns about safety mentioned by his mother.*

• The psychology provision for this patient who demonstrated psychological need and possible safety concerns (regardless of the hypothesised cause) was inadequate.

8. In light of your comments above regarding the required psychology input for transgender patients, please comment whether the psychology input for each patient was adequate, with reference to:

a. Assessment;
Regarding assessment, the witness statement of [Mrs A] *details:*
'We provided Dr Webberley with a copy of all of everything we had received from Tavistock and UCLH which included all of Patient A's assessments and test results. I found Dr Webberley to be very thorough in requesting and going through these results. She asked us lots of questions about what support was in place for Patient A and what our family dynamics were. Dr Webberley explained the services that she could provide and also said that she could offer counselling to Patient A.'
It is common practice for clinicians to rely on thorough, recent assessments conducted by other professionals for the purposes of assessment and diagnosis. The Tavistock assessment appears to me to be rigorous and comprehensive and I think it reasonable for Dr Webberley to incorporate this information to complete the 'non-medical' component of her own assessment as it was completed in July 2015 and her own appointment with [Patient A] took place shortly in March 2016. There was also no documented concern from previous CAMHS assessment or Tavistock assessment that identified and mental health or neurodevelopmental co-morbidities.
However, some attempt at re-assessment and case conceptualisation of psychological status and need should have been attempted before any intervention was considered. In the months between the Tavistock assessment report and Dr Webberley's appointment a great deal of change may have occurred, particularly for someone of [Patient A]'s age, and this would need to be re-established in order to provide safe and effective, formulation driven psychological care.

• There was a failure to reassess the psychological needs and status of [Patient A]. This is of concern as there are many co-morbid conditions that present with gender dysphoria and these can complicate adjustment in response to hormone treatment.
• The standard of psychological assessment was inadequate and this is not in line with NHS service specification or WPATH guidelines.

18. In respect of Patient B, he opined:

'7. Documentation from GenderGP indicates that there was no psychology provision for [Patient B] as part of their treatment from Dr Webberley.

• There was a failure to provide initial and ongoing psychological input for [Patient B] in line with WPATH guidelines and NHS service specification
• This is inadequate care and is of concern in the context of [Patient B]'s mental health needs which include the management of DSH and eating 1124 disorder.
8. In light of your comments above regarding the required psychology input for transgender patients, please comment whether the psychology input for each patient was adequate, with reference to:
c. Assessment;
No psychological assessment was offered to [Patient B] at any point by Gender GP. In a letter dated 11th August 2016 from a doctor (M) to [Patient B]s GP, reference is made to an episode of deliberate self-harm (DSH) and to NHS services providing "… a terrible experience with CAMHS, where they were trying to diagnose him as being autistic because his mother works with children with autism and did not want to recognise the gender issues". On 21st October 2016 the clinic manager enquired of [Patient B]'s mother about having had counselling prior to his referral to Gender GP; which she confirmed. No further mention was made of this. There should have been be more documented exploration of psychological need for an individual with a mental health history such as [Patient B]s. [Patient B] had multiple episodes of DSH and was referred by CAMHS to a DSH follow up appointment after a suicide attempt with paracetamol. Additionally, there was a reported eating disorder (ED), and substantial evidence of a possible autism spectrum condition in NHS clinical notes. A referral was made for an ADOS assessment for autism (assessment summary letter, 11th June 2015 by [Mr YY]*, family therapist, CAMHS; which [Patient B] did not attend.*
• There was a failure to assess [Patient B]s psychological needs. This is of concern as the needs as outlined in NHS documentation were significant and carried a substantial measure of risk
• This standard of care was inadequate

19. The Tribunal consider that these passages in Dr Q's report serve to put Dr Webberley on notice of the extent of the allegation that she failed to arrange for psychological assessments of Patients A and B, and that it was not enough for her to rely upon the assessments of others prior to prescribing testosterone treatment. The Tribunal considered that the addition of the word 'adequately' in paragraphs 1(b) and 3(b) of the Allegation more appropriately reflect the opinion of Dr Q. Further it considers that Dr Webberley will have been on notice of the terms of the allegation since being in receipt of Dr Q's report in late March 2021. Still further, by reason of the fact that Dr Webberley has yet to serve any expert report in relation to these matters, notwithstanding that the application to amend was made on Day 2 of the hearing, no injustice will be occasioned to her, since there is still time for her to obtain expert opinion on the matter.

20. It therefore determined to permit the amendments in respect of paragraphs 1(b) and 3(b) of the Allegation to introduce the word "adequately" before the word "examined" in those paragraphs. Having permitted those amendments, the Tribunal further considered its position in relation to the application to amend paragraph 5(a) of the Allegation. It accepted the point made by Mr Jackson that there is merit in consistency, and by reason that it did not consider that a similar amendment would cause Dr Webberley any injustice, it determined to allow it.

21. In addition, there appeared to be some possible confusion as to the correct date in the stem of paragraph 3 of the Allegation. The precise date is not a significant element of the allegation. The Tribunal determined to resolve the confusion by amending the date to:
'on or about 10 August 2016'

22. The Tribunal was satisfied that these amendments can be made without injustice to Dr Webberley. It therefore decided to grant the application.

ANNEX C – 13/08/2021 - Rule 34(1) Application to admit evidence – 13/08/2021

Submissions

1. On Day 13 of the hearing, the Tribunal determined that it should offer the parties, in particular Dr Webberley, the opportunity to make further submissions in relation to the admissibility of documents which the Tribunal had refused as set out in Annex A. The documents were as follows:

1. A selection of self-referral emails which Dr Webberley had received which highlight the reasons why patients and the public have referred themselves to her;
2. A statement from the mother of a transgender child who describes her experience in the NHS with regard to her son and the experience with Dr Webberley;
3. An email by Dr Webberley to a cardiologist and his response in relation to a transgender patient;
4. A letter from a Consultant Neuropsychiatrist at the Gender Clinic in Daventry dated 18 November 2016 which is a 'thankyou' and a detailed letter regarding a meeting they had as professional colleagues and the matters they discussed and the matters which they might discuss in the future;
5. Letters of support for Dr Webberley written to the GMC from patients or parents of patients following public knowledge of the GMC investigation;
6. Letters of support from transgender organisations (Gires; Mermaids; Unique Transgender Network; Transfigurations).

2. This determination was occasioned following a consideration of Mr Jackson's opening on behalf of GMC and the disclosure of Dr Webberley's witness statement. The parties made further submissions on Day 14 of the hearing. In advance of the oral submissions the GMC conceded that the documents listed as 3 and 4 above were admissible.

3. On behalf of Dr Webberley, Mr Stern made submissions regarding the relevance of these documents and as to whether it was fair that they should be admitted into evidence.

4. In respect of the self-referral documentation (item 1), Mr Stern explained that the emails disclosed why patients were referring themselves to Dr Webberley's portal Gender GP Ltd, the experience which they had undergone with the NHS and why they were seeking her assistance. He argued that it was not unfair to the GMC for this material to be disclosed since the relevant matter was their seeking her assistance. The documents had been in the hands of the GMC for a considerable period; if there was any unfairness the balance favoured the documents being admitted.

5. In respect of the statement from the mother of a transgender child (item 2), he argued that this was relevant as it also included an account of Dr Webberley's management of a child going through transition.

6. In respect of the letters of support for Dr Webberley written to the GMC by patients or parents of patients (item 5), he deployed the same argument. Although he acknowledged that those letters included expressions of opinion, the purpose of presenting them to the Tribunal was to demonstrate Dr Webberley's management of these patients' journeys of transition. Although these documents were written post treatment, he contended that they reflected her management of these cases at the time. Insofar as fairness is concerned, he explained that the identity of the writers had been known to the GMC for a considerable period; the GMC could have conducted an investigation into the accuracy of the accounts which the patients or their parents gave.

7. In respect of the letters of support from transgender organisations (item 6), essentially, he argued that they demonstrate the confidence the organisations had in Dr Webberley's care for patients embarking on gender transition.

8. On behalf of the GMC, Mr Jackson opposed the application save in respect of items 3 and 4. In respect of the self-referral emails (item 1), he argued that the Tribunal should approach the issue of admissibility with caution. In particular he was concerned that the Tribunal should not be influenced by the opinions of the self-referrers as they were not in a position to pronounce on whether or not Dr Webberley was competent. He said that the only relevant evidence as to her competence should come from an appropriately qualified expert; Dr Webberley's competence should not be assessed on the basis of her own assessment and that of lay people.

9. In respect of the statement of the parent of the transgender child (item 2), Mr Jackson said that it was no more than a letter and that whilst it might be admissible if she attended to give oral evidence, it was not appropriate for it to be adduced in written form.

10. In respect of the letters of support of Dr Webberley written to the GMC by patients or their parents (item 5), he again expressed concern that the Tribunal might be influenced by the opinions of lay persons who did not really understand whether or not Dr Webberley was delivering competent care. He argued that, in reality this material amounted to evidence of propensity to treat patients professionally and responsibly, something which Dr Webberley was obliged to do in any event and that it should not be admitted as evidence on the issue of her competence.

11. In respect of the letters from transgender organisations (item 6), Mr Jackson contended that it was not appropriate for the Tribunal to receive evidence from these bodies as to Dr Webberley's competence.

12. Both Mr Stern and Mr Jackson referred to individual self-referral emails and individual letters of support to demonstrate the points which they made. Mr Jackson also relied on his annotations to the note from the Tribunal informing the parties that it was prepared to consider this issue further.

Tribunal Decision

13. The Tribunal reached the following decision in relation to the several categories of documents based upon Rule 34(1) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules').

14. The Tribunal determined to admit documentation at items 3 and 4 above on the basis that the material therein was relevant to the issues in the case and that it was fair to admit it.

15. The Tribunal determined to reject Mr Stern's renewed application that it should admit a selection of self-referral emails (item 1) which Dr Webberley had received, and which highlight why those patients have referred themselves to her. The Tribunal did not consider that this material was relevant since it did not speak to her management of the transgender journeys of these patients.

16. In respect of the statement from the mother of a transgender child (item 2), the Tribunal considered that this was relevant as it dealt with the experience that child had under Dr Webberley management. The Tribunal did not consider that the GMC was under any obligation to adduce this evidence itself and that, if it had the power to require the GMC to call this evidence, it did not consider that it was appropriate for it to exercise that power due to the sensitivity of the subject. The Tribunal considered that, in the first place, Dr Webberley's team should explore whether or not this person could be called as a defence witness. The Tribunal determined to admit her statement or letter. In the event that it is not practicable for the witness to give oral evidence the Tribunal will attach appropriate weight to her statement or letter.

17. In respect of the letters of support for Dr Webberley from patients or their parents (item 5), the Tribunal determined to allow this material to be admitted insofar as it relates to patients under the age of eighteen. On the face of it, this material goes to Dr Webberley's management of these patients and the outcomes which were achieved under her care. It is therefore relevant to the experience Dr Webberley had at the time she was treating Patient A, Patient B and Patient C. Whether or not Dr Webberley, at the material time, was a GP with a special interest in gender dysphoria may depend in part on her experience with such patients. Insofar as this material includes expressions of opinion which do not concern the outcomes achieved, the Tribunal will exercise its professional discretion not to take this into account.

18. The Tribunal has determined not to admit the letters of support from the transgender organisations (item 6) at this stage. The Tribunal considers that this material does not relate to Dr Webberley's management of patients undergoing transgender treatment.

ANNEX D – 14/09/2021 - Rule 34 Application to admit evidence

Submissions for the GMC

1. On Day 35 (14 September 2021), Mr Jackson QC, on behalf of the GMC, makes an application for certain paragraphs of Dr Webberley's Rule 7 response to be adduced in evidence after such time as he has closed the GMC's case. The application specifically relates to paragraph 26 of the Allegation which reads:

> '26. On the governance page of the Gender GP website it states that all medical advice and prescriptions are provided by doctors working outside of the UK.'

2. It will be noted that the paragraph of the allegation is expressed in the present tense. It does not refer to any particular date.

Submissions for the GMC

3. Mr Jackson explained that paragraph 33 of Dr Webberley's response constitutes an admission to paragraph 26 as it was put to her by the Registrar under the Rule 7 procedure. The Tribunal does not have a copy of Dr Webberley's Rule 7 response – it is part of the GMC's procedure to investigate allegations – but it understands that it was drafted by Dr Webberley's solicitors on her behalf and with her approval.

4. Dr Webberley denied paragraphs 26 and 27 of the Allegation at the outset of the hearing.

5. Mr Jackson submitted that the Tribunal should consider whether any injustice would arise if the Tribunal allowed his application, and reminded the Tribunal that it should consider fairness to both parties. He also referred to the overarching objective in Section 1A and 1B of the Medical Act 1983 which provide:

> 1A) The over-arching objective of the General Council in exercising their functions is the protection of the public.
>
> (1B) The pursuit by the General Council of their over-arching objective involves the pursuit of the following objectives—
>
>> (a) to protect, promote and maintain the health, safety and well-being of the public,
>> (b) to promote and maintain public confidence in the medical profession, and
>> (c) to promote and maintain proper professional standards and conduct for members of that profession.

Submissions for the doctor

6. Mr Stern opposed the application in principle. Whilst acknowledging that admissions may amount to an exception to the rule against hearsay, he asserted that it would not be appropriate to allow this evidence to be introduced at this stage when the GMC had closed its case. He had already submitted that there was no evidence introduced by the GMC in relation to this paragraph of the Allegation.

7. Mr Stern also submitted that, if it was admitted, it was something which the Defence could easily deal with since paragraph 34 of Dr Webberley's Rule 7 response explains that she was not responsible for what was set out in the Gender GP web site and that the governance page was written after 5 April 2019.

Tribunal's Decision

8. The Tribunal reminded itself that the admissibility of evidence is governed by Rule 34 of the 2004 Rules which provides:

> '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.'

9. It also had regard to Paragraph (1A) of Schedule 4 to The Medical Act 1983 as amended: Proceedings Before the Investigating Committee, Medical Practitioners Tribunals and Interim Orders Tribunals. That paragraph states as follows:

> *'The overriding objective of the General Council in making rules under this Schedule with respect to the procedure to be followed in proceedings before a Medical Practitioners Tribunal or an Interim Orders Tribunal, or with respect to the procedure to be followed by the Investigation Committee when deciding whether to give a warning under Section 35C6, is to secure that the Tribunal or Committee (as the case may be) deals with cases fairly and justly.'*

10. The Tribunal considers that Rule 34 reflects paragraph 1A of Schedule 4 as set out above. It does not consider that the overarching objective set out in paragraph 1(A) of the Medical Act 1983 should have any bearing on its decision.

11. So far as the issue of relevance is concerned, on the face of it, paragraph 33 of Dr Webberley's Rule 7 response is relevant since it directly addresses the allegation now to be found in paragraph 26 of the Allegation. However, the relevance of her admission is called into question by paragraph 34 of her Rule 7 Response as Mr Stern informed the Tribunal that she says she was not responsible for what was set out in the Gender GP web site. She adds that it was written after 5 April 2019. The Tribunal reflected that for it to understand the significance of that date, it may need to see more of her Rule 7 response. The issue of relevance is not therefore limited to what paragraph 33 says by itself.

12. As to fairness, the Tribunal noted that the Rule 7 procedure is part of the GMC's investigation procedure. A doctor's position in respect of the Notice of the Allegation which is sent to him / her under Rule 15 is taken from the plea at the outset of the hearing. It is not taken from the Rule 7 response. It may be that in cross examination the GMC can explore a doctor's denial of an allegation by reference to his / her Rule 7 response.

13. The Tribunal also reflected that the Registrar will have had a basis for putting the allegation later to be reflected in paragraph 26 of the Allegation to Dr Webberley in the Rule 7 procedure. Yet the GMC is seeking to rely, in response to Mr Stern's application of no case to answer, solely on the response of Dr Webberley to that allegation. It is not seeking to rely upon the material which formed the basis of the allegation in the first place. The Tribunal noted that when Mr Jackson opened the case, he did not deal with the paragraphs related to Gender GP at all, including paragraph 26.

14. Taking these matters into account, the Tribunal has reached the conclusion that the issue of relevance is questionable without opening significant parts of the Rule 7 procedure; the issue of fairness is concerning since the GMC appears to be presenting the case in relation to paragraph 26 solely on the basis of Dr Webberley's alleged admission in the Rule 7 procedure – not on any other basis.

15. In view of the fact that the paragraphs of the allegation which relate specifically to Gender GP, namely paragraphs 24 to 27 are not date specific, it is not clear that even if paragraphs 26 and 27 were proved, they would necessarily implicate Dr Webberley.

16. Taking all these mattes in the round, the Tribunal has determined to reject Mr Jackson's application.

ANNEX E – 20/09/2021 - Rule 17(2)(g) Application - Half-time Submissions

1. On 13 September 2021 (Day 34), Mr Stern QC made an application under Rule 17(2)(g) of the Rules, in relation to paragraphs 7, 8, 15, 16, 17, 18, 19, 20, 21(b), 22, 23, 24, 25, 26 and 27 of the Allegation.

2. 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."

3. The allegations are:

<u>CQC – Dr Matt Limited</u>

7. On the dates set out in Schedule 1, you inappropriately prescribed an increased dose to Patient D through a pharmacy website without any evidence that the change in dose was correct.

8. On 26 August 2016, you dealt with Patient E's medication request made through a pharmacy website and you:

a. failed to:

i. adequately assess Patient E in that you did not seek further details of:
1. their symptoms; To be determined
2. why they thought they had a STI;

ii. refer Patient E to a Genito Urinary Medicine clinic for further investigations and/or tests;

iii. provide follow up advice in that you did not advise Patient E to attend at a GUM clinic in the event that they were suffering from a STI;

iv. record your:
1. assessment of Patient E as set out at paragraph 8ai above;
2. referral of Patient E to a GUM as set out at paragraph 8aii above;
3. follow up advice to Patient E as set out at paragraph 8aiii above;

b. prescribed 'Doxycycline 100mg 2 daily for 2 weeks' to Patient E which was not clinically indicated because you did not:

i. adequately assess Patient E as set out at paragraph 8ai above;

ii. refer Patient E for further investigations as set out at paragraph 8aii above.

Work Details Form

15. You completed and signed a Work Details Form ('the WDF') on 5 March 2017 in which you failed to declare that you were sub-contracted to provide medical services to Frosts Pharmacy until 24 May 2017.

16. When you completed the WDF, you knew you were sub-contracted to provide medical services to Frosts Pharmacy until 24 May 2017.

17. Your conduct as described at paragraph 15 was dishonest by reason of paragraph 16.

Suspension from the Medical Performers List

18. On 25 April 2017 you were suspended from the Medical Performers List and you failed to notify Frosts Pharmacy of this.

19. You knew that you were required to inform Frosts Pharmacy of your suspension from the Medical Performers List.

20. Your conduct as described at paragraph 18 was dishonest by reason of paragraph 19.

Aneurin Bevan University Health Board

21. In July 2017 a review was initiated by Aneurin Bevan University Health Board ('the Health Board') into your on-line prescribing practices ('the Review') and you:

a. repeatedly frustrated the Health Board's attempts to carry out the Review in that you:

i. consistently challenged the Review where there was no basis to do so, in that you questioned the:

1. terms of reference;
2. competence of the investigators;
3. training of the investigators;

4. the proposed CQC methodology;

ii. continued to challenge the Review as set out at paragraph 21ai above when investigators visited your house on 5 October 2017, preventing any progress to the Review;

b. failed to advise the Health Board throughout the period of the Review of open GMC investigations against you.

22. During the Review, you knew that you were:

a. the subject of open GMC investigations;

b. required to inform the Health Board of ongoing GMC investigations.

23. Your conduct asset out at paragraph 21b was dishonest by reason of paragraph 22.

Gender GP

24. Alongside Dr SS, you operate and control the company known as Gender GP, through which you provided care and treatment.

25. As the principal provider of the Gender GP website, offering hormonal treatment to children, you failed to appropriately reference:

a. the input of any accredited paediatrician/paediatric specialist;

b. your safeguarding policy.

26. On the governance page of the Gender GP website it states that 'all medical advice and prescriptions are provided by doctors working outside of the UK'.

27. The operating method of Gender GP as set out at paragraph 26 above is motivated by efforts to avoid the regulatory framework of the United Kingdom, including regulation by the:

a. CQC;

b. HIW;

c. GMC.

Submissions for Dr Webberley

4. Mr Stern submitted that paragraphs 7, 8, 15, 16, 17, 18, 19, 20, 21(b), 22, 23, 24, 25, 26 and 27 of the Allegation could not be found proved . He referred the Tribunal to relevant case law in support of his application.

<u>In relation to allegations 7 and 8</u>

5. Mr Stern submitted that these paragraphs related to Patient D and Patient E to whom Dr Webberley had prescribed when she undertook work for Dr Matt Limited. He said that the allegations have arisen from Dr O's comments in his reports of 6 June 2018, 5 August 2018 and 6 February 2021, in which he criticised the care and treatment provided by Dr Webberley to Patient D and Patient E, as set out in the particulars. Mr Stern told the Tribunal that Dr Webberley had already made it clear to the GMC in 2018 that the clinical records provided to Dr O are incomplete, and yet the GMC made no attempts to obtain the missing records until 2021. Mr Stern reminded the Tribunal that in his oral evidence, Dr O acknowledged that if he had access to the full records, his opinion might have been different. Mr Stern submitted that, in any event, had the GMC sought to obtain the records in 2018, it would have made no difference as by then, Etail, the company responsible for the management of all of the clinical records held by DMC, was no longer in operation. He relied upon and referred the Tribunal to the email of 14 July 2021 from DMC in which it stated:

> *"Dr Matt Ltd was closed as an entity. Staff at DMC have repeatedly tried and failed to contact Etail - this was the provider of the clinical record system to Dr Matt Ltd, where the detail of the two cases will have been recorded. We think that as an entity Etail may no longer be in existence. We are investigating this possibility. We understand the legal nature of the request and the urgency. We did not hold the record keeping system, which I understand was run and owned by Etail. We do not have access to the clinical record system and as above, we have been trying to secure the details from the entity that may have been dissolved."*

6. Mr Stern submitted that despite this, Dr Webberley happened to have in her possession emails with regard to the two patients which clearly described that a review was necessary. Mr Stern submitted that in the absence of any such records being adduced by the Tribunal, there was no evidence upon which a reasonable Tribunal could find either of these paragraphs of the Allegation proved.

<u>In relation to allegations 15 – 17</u>

7. Mr Stern reminded the Tribunal that during his oral evidence, Mr R stated that services provided by Dr Webberley to Frosts Pharmacy Limited (FPL) were by way of a contract between Online GP Services Ltd (OGPSL) and that the contract was terminated in

May 2017; and that Mr R confirmed that OGPSL and not Dr Webberley was paid for services up to 21 May 2017. Mr Stern submitted that in her completed Work Details Form (WDF) dated 5 March 2017, Dr Webberley had correctly recorded under question 3.2 'Where do you currently work?' that she worked for OGPSL. He submitted that this was an accurate entry. Mr Stern also referred the Tribunal to the notes of the PACE interview of 24 April 2017 in which he said there was no suggestion that Dr Webberley was contracted to provide services for FPL. Mr Stern submitted that there is no evidence to support the allegations set out in paragraphs 15 – 17.

<u>In relation to allegations 18 – 20</u>

8. Mr Stern took the Tribunal through the chronology leading up to Dr Webberley's suspension from the NHS Medical Performers List (MPL) of the Aneurin Bevan University Health Board (ABUHB) on or around 25 April 2017. He said that there is no mention in the letter from ABUHB to Dr Webberley, dated 28 April 2017, requiring her to inform anyone of her suspension from the MPL and therefore Dr Webberley did not inform FPL. Mr Stern reminded the Tribunal that in their opening, the GMC acknowledged that Dr Webberley was not strictly required to inform FPL of her suspension as she did not need to be on the MPL to undertake work for FPL. He submitted that the GMC has based the allegation on a reasonable expectation but submitted Dr Webberley was under no duty to do so.

<u>In relation to allegations 21(b) – 23</u>

9. Mr Stern submitted that the ABUHB instigated the review in July 2017 and stated that, by this time, the ABUHB was already aware that the GMC had opened an investigation against Dr Webberley. In this regard, he referred the Tribunal to the Situation-Background-Assessment-Recommendation (SBAR) Report, dated 11 April 2017, prepared by Dr N. Mr Stern drew the Tribunal's attention to a paragraph in which it stated 'These concerns have been elevated to the General Medical Council (GMC).' Mr Stern went on and referred the Tribunal to the letter sent from Dr Webberley's then legal representatives, Carbon Law Partners, to ABUHB, dated 23 June 2017, in which under the heading 'GMC's concurrent investigations: double jeopardy' it is stated *'Dr N had previously referred these concerns to the GMC. On 24 March 2017, Dr N was advised by the GMC that a full investigation had been opened.'*

10. Mr Stern told the Tribunal that in its letter of 20 March 2017, to Dr Webberley, the GMC advised her that it had also informed her Responsible Officer (RO) that the GMC had opened an investigation into the concerns. Mr Stern said that Dr OO was Dr Webberley's RO at the time. Mr Stern submitted that therefore there was no requirement for Dr Webberley to inform ABUHB that she was subject to an investigation by the GMC because ABUHB was already aware of it. He submitted, therefore, that this allegation could not be found proved.

In relation to allegations 24 – 27

11. Mr Stern submitted that these allegations lacked clarity because some were written in the past tense and some in the present tense. He said that the GMC had not provided any evidence to support these allegations and he referred the Tribunal to various documentation within the hearing bundles stating that there is no evidence before the Tribunal which required Dr Webberley to make reference to a paediatrician or paediatric specialist on the website. Mr Stern went on to refer the Tribunal to the screenshot of the Gender GP website homepage and, whilst he acknowledged the date the screenshot was taken was unknown, he said that the link on the Homepage which read 'Safeguarding Policies' was sufficient evidence such that the Tribunal could not find this allegation proved. In respect of paragraph 26 of the Allegation, Mr Stern submitted that there was no evidence provided by the GMC and therefore the Tribunal could not find this allegation proved. Mr Stern said that as a consequence of there being no evidence to support allegation 26, the Tribunal could not find allegation 27 proved. He added that it was illogical that where a surgery or business was registered in Wales, that you fall outside of the CQC's jurisdiction. He went on to say that a business which fell within the relevant legislation, must be registered with HIW and that Dr Webberley attempted to register accordingly. The GMC has jurisdiction to regulate any doctor registered with it no matter where they practise, nationally or internationally.

12. He said that on the balance of probabilities, there was no evidence on which the Tribunal could find these paragraphs of the Allegation proved. He invited the Tribunal to grant the application.

On behalf of the GMC

13. Mr Jackson QC opposed the application. He reminded the Tribunal of the test to be applied and referred to relevant case law to support his argument.

14. Mr Jackson said that it was important not to conflate two distinct and clear principles of law when considering the submissions made by Mr Stern. Mr Jackson said that the important principle at this stage of the proceedings was whether there is sufficient evidence to support the allegations as set out. He said that it was important that the Tribunal hears from Dr Webberley in respect of missing clinical records before it could make a decision as to whether it is satisfied there are missing records. He said that only then could the Tribunal determine whether these allegations are found proved or not, and that to decide whether these allegations could be found proved or not at this stage of the proceedings would be premature.

15. Mr Jackson submitted that reliance upon an argument which relates to missing documents would usually be made in an application of abuse of process and in this regard, he referred the Tribunal to relevant case law. He went on to say that whilst the focus of abuse cases is often the issue of delay and/or missing documents, the key principle to be extracted is that such claims of alleged unfairness to the registrant very rarely resulted in stopping the case or the striking out of the allegations at this stage of the proceedings.

In relation to allegation 7

16. Mr Jackson submitted that there was no duty on the GMC to trace all possible documentation and that the primary issue before the Tribunal was whether there is sufficient evidence to find the allegations proved. He said that if the Tribunal finds during its deliberations on the facts that the GMC has failed to obtain sufficient evidence to prove its case in relation to the allegation, then it could make a decision as to whether or not the allegation is found proved. He reminded the Tribunal that it had not yet heard Dr Webberley's evidence on this matter.

17. Mr Jackson took the Tribunal to the oral evidence of Dr O and to Dr O's comments set out in his reports as to the care and treatment provided by Dr Webberley to Patient D and that her prescribing an increased dose of Metformin without the appropriate or adequate assessment could have placed Patient D at risk of harm. Mr Jackson referred the Tribunal to the screenshot of the questionnaire completed by Patient D in which there was no information to suggest that Patient D had not requested an increased dose on 23 September 2016 or why Dr Webberley had increased the dose prescribed.

18. Mr Jackson submitted that based on the evidence before it, the Tribunal could find this allegation proved.

In relation to allegation 8

19. Mr Jackson reminded the Tribunal of Dr O's evidence as set out in his reports – that a reasonably competent GP would not have treated a sexually transmitted disease (STD) "blind" with antibiotics because of the need to ensure that the right treatment was given for the infection, and that given Dr Webberley was aware Patient E had an STD, the failure to ensure adequate tests and investigations was (seriously) below the expected standard expected. Mr Jackson submitted that on the evidence before the Tribunal, which include some record of correspondence between Patient E and OGPSL but no record that Dr Webberley conducted a consultation with Patient E or the nature of any such consultation prior to prescribing the medication, this allegation could potentially be found proved.

In relation to allegations 15 – 17

20. Mr Jackson said that all doctors have a duty to disclose to their employer and any other organisations for whom they had a contract to provide medical services of any open investigations against them. He said that doctors are responsible for ensuring the accuracy of any information provided on any forms completed by them, and he referred the Tribunal to paragraphs 65, 66, 71 and 73 of Good Medical Practice (GMP). In particular, Mr Jackson submitted that paragraph 71 is relevant which states:

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

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

b You must not deliberately leave out relevant information.'

21. Mr Jackson reminded the Tribunal of the evidence of Mr R of FPL that Dr Webberley approached FPL to provide an online prescribing service for FPL, and that she did provide those services after she was removed from the MPL. Mr Jackson submitted that this demonstrated that Dr Webberley knew that she was contracted to provide medical services for FPL. Mr Jackson went on to say that question 3.2 of the WDF was clear as to the information being sought and that Dr Webberley therefore deliberately omitted to include this information in her WDF. He submitted that the Tribunal could, in due course, based on the evidence before it, find this allegation proved and that Dr Webberley's action in omitting this information was dishonest.

<u>In relation to allegations 18 – 20</u>

22. Mr Jackson submitted that Dr Webberley had a duty to declare that she had been suspended from the NHS Medical Performers List (MPL) and that Dr Webberley should have informed FPL of this. He reminded the Tribunal that in the letter from ABUHB dated 28 April 2017, it stated *'During the period of suspension you should refrain from providing primary medical services for a primary care organisation in Wales in any capacity whatsoever.'* He also reminded the Tribunal of Mr R's evidence that he only became aware that Dr Webberley had been suspended from the MPL when he was contacted by the GMC in relation to its investigation.

23. Mr Jackson acknowledged that FPL operated from Oxford, England, but submitted that the ambit of the suspension meant that Dr Webberley should not provide any medical services in Wales. Further, Mr Jackson stated that whilst there was no legal requirement upon Dr Webberley to notify FPL of her suspension, there is a reasonable expectation on doctors to keep their employers aware of significant changes to their professional standing. Mr Jackson submitted that as FPL was technically Dr Webberley's employer for the purposes of online prescribing, there was a reasonable expectation upon her to inform them of her suspension, and that not to do so ran the risk of damaging public confidence in the medical profession. In support of the argument advanced, Mr Jackson referred the Tribunal to paragraphs 56. 66 and 76 of GMP, which relate to acting with honesty and integrity, and being open about any legal or disciplinary proceedings.

24. Mr Jackson submitted there is evidence upon which the Tribunal could find this allegation proved.

In relation to allegations 21(b) – 23

25. Mr Jackson submitted that as her designated body, and the fact that Dr OO was Dr Webberley's RO, there was a duty upon Dr Webberley to notify ABUHB that there was an open GMC investigation against her. He reminded the Tribunal of Dr N's evidence that during his dealings with Dr Webberley, Dr Webberley never notified him of the ongoing GMC investigation into her practice. Mr Jackson referred the Tribunal to regulation 9 of the Regulations which state:

> *'9.— Requirements with which a performer in a performers list must comply*
> *(1) A performer, who is included in a performers list of a Local Health Board, shall make a declaration to that Local Health Board in writing within 7 days of its occurrence if the performer–*
> *…*
>
> > *(h) is informed by any licensing, regulatory or other body of the outcome of any investigation into the performer's professional conduct, and there is a finding against*
> > *the performer;*
> >
> > > *(i) becomes the subject of any investigation into the performer's professional conduct by any licensing, regulatory or other body;*
> > > *…'*

26. Mr Jackson submitted that paragraphs 1, 65 and 73 of GMP applied in this respect. He said that once the GMC had opened an investigation into Dr Webberley's clinical practice, she was under a duty to notify the ABUHB of this. He added that the fact that ABUHB was aware of this via another route did not negate that duty. Mr Jackson said that Dr Webberley should not have simply relied on the GMC to inform ABUHB of the open investigation against her. Mr Jackson stated that given Dr Webberley accepts that she failed to declare the ongoing GMC investigation to ABUHB, there is clearly evidence upon which the tribunal could find this charge proved.

In relation to allegation 24

27. Mr Jackson referred the Tribunal to the letter from Dr Webberley's then legal representatives, Burton Copeland, dated 31 August 2016 in which they provide Dr Webberley's XXX for GenderGP. He said that when completing and signing her WDF for GenderGP and OGPSL, Dr Webberley described herself as 'Lead Clinician/Company Director'. During the PACE interview, Dr Webberley stated that she was 'running the service'. Mr Jackson stated that in his SBAR Report, Dr N stated that Dr Webberley had a controlling interest in three companies, GenderGP Limited, My Web Doctor Limited, and OGPSL.

28. Mr Jackson submitted that there is sufficient evidence before the Tribunal for it to find this allegation proved.

In relation to allegations 25a and 25b

29. Mr Jackson relied upon the SBAR Report in which Dr N states:

> *'Dr Helen Webberley is the principal provider of service on the website. In doing so the website states she states that she is supported by a number of individuals including* [XXX] *Dr SS, a consultant gastroenterologist, who advises on endocrinology, a number of counsellors, a speech and language therapist and others. Although the website based service offers hormonal treatments to children the website does not reference the input of accredited paediatricians. Nor is there any reference to a child safeguarding policy on the website.'*

30. Mr Jackson stated that the date of the SBAR Report of 11 April 2017 was relevant to the allegations and reminded the Tribunal that Dr N was not cross examined about these matters in his report in respect of his comment about there being no reference paediatrician or paediatrician specialist when offering hormone treatment to children within a multi-disciplinary team approach. Nor, Mr Jackson submitted, was there any challenge at cross examination to the reference about the Safeguarding Policy.

31. Mr Jackson submitted that there is evidence upon which the Tribunal could find these allegations proved.

<u>In relation to allegations 26 - 27</u>

32. Mr Jackson submitted that the reference on the governance page of Gender GP that *'all medical advice and prescriptions are provided by doctors working outside of the UK'*. He submitted that this could only be intended to avoid the UK regulatory framework of the GMC and other regulatory authorities. Mr Jackson submitted that there is sufficient evidence before the Tribunal to find this allegation proved.

33. Mr Jackson submitted that the Tribunal could, in due course, find these paragraphs of the Allegation proved, and he invited the Tribunal to refuse the application.

Tribunal's Decision

34. Mr Stern cross examined Dr O, amongst other matters, on the basis of three emails to which this determination refers. These did not form part of the exhibits adduced by the GMC, although it is possible that they were in the bundle of documents sent to Dr O in order to enable him to prepare his expert reports. In the relevant exhibit, Dr Webberley's commentary on those emails was included. An issue arose as to whether the Tribunal should take these emails into account when considering Mr Stern's submission of no case to answer in respect of paragraphs 7 and 8 of the Allegation, since ostensibly they emanated from the Defence.

35. Mr Stern's submission was that the Tribunal should find that there was no case to answer in respect of paragraphs 7 and 8 of the Allegation as the GMC's case was based on an

analysis of the documents relating to Dr Webberley's online prescribing whilst working for Dr Matt Ltd and the GMC did not have all the records relating to that online prescribing. In the course of submissions, it was recognised that that submission might be understood as a submission of abuse of process on the basis that Dr Webberley could not have a fair trial if the GMC's case was presented on the basis of an incomplete set of records. Mr Jackson submitted that the Tribunal could take those emails into account if and when the Tribunal was considering the issue of abuse of process, but not when considering Mr Stern's submission of no case to answer. Mr Stern submitted that they should be taken into account in both eventualities; that they were clearly genuine contemporaneous documents and they had been in evidence during the GMC's case.

36. The Tribunal determined to take them into account when considering both the submission of no case and abuse of process. It considered it was artificial to admit documentation in one set of circumstances and not in another, particularly as the emails had been in evidence during the GMC case. It would not however take Dr Webberley's commentary on those emails into account, unless in the course of that commentary, Dr Webberley admitted a paragraph of the Allegation. The explanation for this is that any such admission will have been advanced by the defence during the course of the GMC case.

Paragraph 7

37. The application is dismissed. The Tribunal find that Dr Webberley has a case to answer in respect of Paragraph 7 of the Allegation.

38. Paragraph 7 of the Allegation alleges that on 23 September 2016, Dr Webberley inappropriately prescribed an increased dose of Metformin (850 mg 1 tablet 2 to 3 times a day, 168 tablets) to Patient D through Dr Matt Ltd, a pharmacy website, without any evidence that the change in dose was correct.

39. Dr Webberley had prescribed Metformin (500 mg 1 tablet 2 to 3 times a day) on 5 August 2016.

40. The Tribunal noted the CQC report into Dr Matt Ltd which was dated 6 April 2017. That report states the following in relation to the system for prescribing at Dr Matt Ltd:

> *'Patients completed an online form which included their past medical history, symptoms and any medication they were currently taking. There was a set template to complete for the prescription request that included the reasons for the request and the outcome to be manually recorded on the patient record, along with any notes about past medical history and diagnosis.*
> *Patients would also be responsible for selecting what dose of medication they required which should be the responsibility of the clinician.'*

41. The CQC report also included the following observations:

> *‘We reviewed 25 anonymised medical records which demonstrated notes had not been adequately completed. Record keeping was inconsistent and not all patient information gathered was attached to the patient record. We also found that all 25 completed online questionnaires had each been analysed by the GP in less than one minute and found that one had been analysed in 17 seconds.’*

42. The documents adduced by the GMC showed that the prescription request from Patient D for several medications including Metformin dated 23 September 2016 was placed at 08:28:17. It bore the Order Number 3069. At that time, it was marked Questionnaire Pending. At 20:38 it was the subject of an email to Dr Webberley from the Online Surgery as follows:

> *‘H. • The order #3069 (Next 2-3 working days). p aced by vi� A...i s now n status of Awaiting Review. Th s order requ res your act on. P ease og n to your dashboard to check order deta s. Thanks. Th On neSurgery’* [sic]

43. It is apparent that the request had by that time passed the Questionnaire Pending Stage and was awaiting review by Dr Webberley. Following the review, the doctor is in a position to issue the prescription. Although the prescription is signed (electronically) by Dr Webberley, thereby confirming that she carried out the review, the documents do not disclose when the review was carried out nor when the prescription was issued. Moreover, there were no documents relating to the review.

44. Mr Stern’s submitted that, as (it was common ground that) the documentation relating to online prescribing at Dr Matt Ltd was not complete, in the absence of that documentation, it cannot be proved that Dr Webberley inappropriately prescribed Metformin to Patient D on 23 September 2016. As there is no evidence as to her rationale for the prescription, the GMC cannot say that it was inappropriate.

45. The Tribunal has to consider whether there is sufficient evidence upon which it could conclude that Dr Webberley inappropriately prescribed Metformin to Patient D in the absence of any documentation relating to the prescription.

46. There is no communication between the patient and the doctor on the documents before the Tribunal. Absent evidence of any communication between Patient D and Dr Webberley, there is no reason to consider whether the review conducted by Dr Webberley before issuing the prescription was other than on the basis of Patient D’s request for a prescription.

47. The questionnaire completed by Patient D in respect of his request for the prescription on 23 September 2016 was not materially different from that on 5 August 2016.

48. In his evidence Dr O stated the normal maximum daily dose of metformin is 2000mg though 2400mg can be prescribed. In his oral evidence he said:

'As I say, I would not raise an issue with the prescribing of 500 mg of metformin. This was based upon the patient's original statement and reliance on her being honest about having checked with the GP and that's what she was prescribed. The issue here, in my opinion, is that suddenly the request, the dose prescribed was increased from 500 mg up to three times a day up to 850 mg three times a day. Now, that may well have been done by the GP based on blood tests, in particular haemoglobin A1c, but there's nothing in the record to indicate that Dr Webberley knew why this had been increased and, whilst I accept that in these cases you're often relying on patients honestly telling you what their results are, I would have expected some enquiries to the patient as to why her medication had suddenly been increased quite considerably.'

and

'I would expect generally in the record when the prescription for the increased dose of medication, the metformin, was – when the increased dose was prescribed I would have expected to find in the record some query from the doctor to the patient as to asking the patient for an explanation.'

49. As there is no evidence that Dr Webberley had a consultation with Patient D before the review which led to the prescription on 23 September 2016 and there is evidence that the increased dose was prescribed to Patient D without evidence warranting the change, the Tribunal has concluded that Dr Webberley has a case to answer in relation to paragraph 7 of the Allegation.

50. The Tribunal did consider whether it would be appropriate to order a stay of paragraph 7 of the Allegation on the basis that Dr Webberley could not receive a fair trial if the GMC was unable to present to the Tribunal a full record of her online prescribing.

51. The Tribunal had regard to *R v. Mackreth*. It did not consider at this juncture that the evidence demonstrated that there was likely to be documentation which might assist on this matter. It therefore determined not to accede to a submission of abuse of process in relation to paragraph 7 of the Allegation.

Paragraph 8

52. The application is accepted in part. the Tribunal find that Dr Webberley does not have a case to answer in respect of Paragraph 8 of the Allegation, save in respect of paragraph 8(a)(ii) and (iii) and Paragraph 8(b)(ii).

53. Paragraph 8 of the Allegation alleges that, following Patient E's request for Doxycycline medication on 26 August 2016 through Dr Matt Ltd, she failed to adequately assess Patient E, refer him to a Genito Urinary clinic for further investigations, provide follow up advice and record her assessment of Patient E, her referral and her follow up advice and that she prescribed Doxycycline 100 mg 2 daily for 2 weeks to Patient E when this was not clinically indicated.

54. The Tribunal does not repeat the evidence of the system for prescribing at Dr Matt Ltd set out in its determination concerning the submission of no case to answer in relation to paragraph 7 of the Allegation.

55. In the case of Patient E, the documents adduced by the GMC showed that the prescription request from Patient E for Doxycycline was dated 26/8/16. It was awaiting review at 6:24:41 and in review at 6:24:55 on that day. It is not possible to say on the documents when the prescription was issued by Dr Webberley, but the medication was pending shipment at 10:02:31 on 30 August 2016.

56. The papers contain 2 emails as follows:

> *'From:* [XXX]
> *Subject: FW: RE:order request*
> *Date: 30 August 2016 at 08:54*
> *To: Dr He en Webber ey he en.webber e*
> *HI helen, This patient has responded to you about 12 hours back and looks to be in agony from his emails. Can you please revert back to him quickly. Regards,* [XXX]'
>
> and
>
> *'From:* [XXX]
> *Sent: 27 August 2016 16:45*
> *To: TOS Care*
> *Subject: RE:order request*
> *To whom it may concern*
>
> *I made a request for Doxycycline tablets,and received an email from the team stating that the doctor would like to ask a few more questions.*
>
> *However, I am unable to log into your online account, and as well i have left a few voice messages on your 0800 contact number ..*
>
> *I would be most grateful if someone could ring from your team to discuss any query further on , thank you.*
>
> *Kind regards*
> *……..'*

57. These emails suggest there was an engagement between Patient E and Dr Matt Ltd following Patient E's request for a prescription. This evidence points to some dialogue between Patient E and Dr Matt Ltd following the email from the team that the doctor would like to ask a few questions. The email from DMC Healthcare to Dr Webberley on 30 August 2016 suggests that Dr Webberley has been in communication with Patient E – although the

method of that communication is not clear – and that she was being asked to contact him again urgently.

58. Mr Stern submitted that, as (it was common ground that) the documentation relating to online prescribing at Dr Matt Ltd was not complete, in the absence of that documentation, it cannot be proved that Dr Webberley failed to adequately assess Patient E, refer him to a Genito Urinary clinic for further investigations, provide follow up advice and record her assessment of Patient E, her referral and her follow up advice and that she prescribed Doxycycline 100 mg 2 daily for 2 weeks to Patient E when this was not clinically indicated. As there was some evidence of a consultation, the GMC cannot prove that the consultation did not address the matters in Paragraph 8(a) of the Allegation and in consequence prescribed Doxycycline when it was not clinically indicated. He contended that the emails make it clear that there is further documentation relating to the prescription of Doxycycline to this patient.

59. The Tribunal has to consider whether there is sufficient evidence upon which it could conclude that Dr Webberley did not address the matters in Paragraph 8(a) of the Allegation and in consequence prescribed Doxycycline when it was not clinically indicated in the absence of this documentation.

60. The Tribunal finds that there is not sufficient evidence upon which it could find paragraphs 8(a)(i) and (iv) and 8(b)(i) proved in the absence of this documentation. As there is some evidence of a consultation between Patient E and Dr Webberley on or before 30 August 2016, and the GMC has not obtained any documentation relating to that consultation, the Tribunal considers that the GMC cannot prove that Dr Webberley failed to adequately assess Patient E and record that assessment.

61. The papers include an admission by Dr Webberley that she did not refer Patient E to a Genito Urinary Medicine Clinic or advise her to attend such a clinic in the event that they were suffering from a STI. There is therefore sufficient evidence upon which the Tribunal could conclude that paragraphs 8(a)(ii) and (iii) and 8(b)(ii) could be proved.

Paragraphs 15, 16 and 17

62. The application is accepted. The Tribunal finds that Dr Webberley does not have a case to answer in respect of Paragraphs 15, 16 and 17 of the Allegation.

63. Paragraph 15 of the Allegation alleges that Dr Webberley failed to declare on the WDF that she was sub-contracted to provide medical services to FPL until 24 May 2017.

64. The GMC relies upon the following paragraphs of GMP 2013 to establish that Dr Webberley was under a duty to disclose that she was subcontracted to provide medical services to FPL:

'Act with honesty and integrity

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

66 You must always be honest about your experience, qualifications and current role. …

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

a You must take reasonable steps to check the information is correct.
b You must not deliberately leave out relevant information.

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

65. The relevant parts of the WDF and Doctor Webberley's completion of it in italics read as follows:

'About this form

We use the details provided in this form to disclose information about what we are investigating to the appropriate people for whom you work or provide services.

When doing so, we will ask them whether they have any other information relating to your fitness to practise medicine.

You should ensure the details are accurate and up to date to avoid information being sent to someone incorrectly.

If your work details change during the provisional enquiry, you should get in touch to up date us or request a new form. If after the provisional enquiry we conclude that the complaint needs to be investigated further, you may be asked to complete further forms.

Section one - Incident Details

1.1 The information which we have received suggests that you were working at the following organisation ***at the time of the incident****:*

'Online GP Services Ltd c/o Max Office Support – via MyWebDoctor

Incorrect.

Online GP Services Ltd via [XXX]

1.2	*Are these details correct?*				*If your answer is No, provide correct detail of the organisation at which you were working at the time of the incident.*
	Yes		*No*	√	*Online GP Services Ltd,* *t/a* [XXX] *And* [XXX]

1.4 Your job title at the time of the incident

CEO
Medical Director

Section 3 – Current Work

3.2 Where do you work currently?

Provide details of the organisation and the site where you are based to provide NHS and / or non-NHS work in relation to any area of medicine, e.g. the Practice or Hospital. For GPs also note the contracting body, i.e. Health and Social Care Board, NHS England Regional Team, Health Board or Local Health Board. Please use a separate sheet to provide further detail is required.

Name/address of the organisations	*Job title and grade*	*Dates of employment*
Online GP Services Ltd *t/a my web doctor and* *t/a gender GP* *[address]*	 *CEO and* *Medical Director*	 *18.11.14 to present*
Freelance GP *Aneurin Bevan Local Health Board*	*NHS* *GP*	*01.06.16 to present*

Section 5 – Private Work

If you have a private clinic offering services in or in relation to any area of medicine, provide the name, address and provide the name of the manager of the clinic or organisation.

As previously described.
Online GP Services Ltd
Address

I am the manager

Declaration

I have provided the GMC with accurate details of my current and previous work as required.

I confirm that I have provided these details truthfully and in good faith.

I will let the GMC know immediately if any of my work details change.

Signed: H Webberley   05 03 2017'

66. The particular paragraph of the form upon which the GMC relies in support of its allegation that Dr Webberley failed to declare that she was sub-contracted to provide medical services to FPL is paragraph 3.2. However, that was a request for her to provide details of the organisation and the site where *'you are based'* to provide NHS and / or non-NHS work in relation to any area of medicine. She was not based at FPL and did not work for FPL in a personal capacity. The contract to provide medical services for FPL was not with Dr Webberley but with OGPSL.

67. The opening paragraphs of the form inform Dr Webberley that she may be asked to complete further forms. The GMC did not ask her to complete any further forms in relation to her company OGPSL, in particular asking about the medical services which it offers to its contractual partners.

68. Notwithstanding that the Tribunal fully understands the purpose of the GMC issuing the WDF to a medical practitioner, it does not find that Dr Webberley has a case to answer in failing to declare that she was sub-contracted to provide medical service to FPL when she was not. Paragraph 15 of the Allegation therefore falls.

69. In consequence the Tribunal finds Dr Webberley has no case to answer in respect of Paragraphs 16 and 17 of the Allegation.

Paragraphs 18 to 20

70. The application is refused. The Tribunal finds that Dr Webberley does have a case to answer in respect of Paragraphs 18 to 20 of the Allegation.

71. Paragraph 18 of the Allegation alleges that Dr Webberley failed to notify FPL that she was suspend from the MPL.

72. Dr Webberley was suspended from the MPL on 25 April 2017. She did not inform FPL of this.

73. The GMC relies on the following paragraphs of GMP (2013) to establish that she was under a duty to do so:

> *'Honesty and integrity*
>
> *65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.*
>
> *66 You must always be honest about your experience, qualifications and current role.*
>
> *Openness and legal or disciplinary proceedings*
>
> *76 If you are suspended by an organisation from a medical post, or have restrictions placed on your practice, you must, without delay, inform any other organisations you carry out medical work for and any patients you see independently.'*

74. The Tribunal finds that by reason of paragraph 76 of GMP, Dr Webberley has a case to answer in respect of paragraph 18 of the Allegation.

75. Although Mr Stern did raise the issue as to whether Dr Webberley knew she was required to inform FPL of her suspension – the subject of paragraph 19 of the Allegation, the Tribunal considers that she has a case to answer in respect of this paragraph as doctors may be taken to know their obligations under GMP. That a doctor does not need to be on the MPL for them to operate within private services (the evidence of Mr R) is not, on the face of it, relevant to the disclosure obligation set out in GMP. Accordingly, the Tribunal finds that Dr Webberley has a case to answer in respect of paragraph 19 of the Allegation.

76. Mr Stern's submission of no case to answer in relation to paragraph 20 of the Allegation was predicated on his establishing that Dr Webberley has no case to answer on paragraphs 18 and / or 19 of the Allegation. As those submissions have failed, the Tribunal find that she has a case to answer in respect of paragraph 20 of Allegation.

Paragraphs 21(b) to 23

77. The application is accepted, save in respect of paragraph 22(a) of the Allegation. The Tribunal finds that Dr Webberley does not have a case to answer in respect of Paragraphs 21(b), 22 and 23 of the Allegation.

78. Paragraph 21(b) of the Allegation alleges that Dr Webberley failed to advise the Health Board of open GMC investigations against her throughout the period of the review which was initiated into her on-line prescribing practices. As the stem of paragraph 21 states, the review was initiated in July 2017.

79. Mr Jackson submitted that Dr Webberley was obliged to disclose the open GMC investigations against her by virtue of the following:

> *'Regulation 9 of the National Health Service (Performers Lists) (Wales) Regulations 2004 which provides:*
>
> > *9.— Requirements with which a performer in a performers list must comply*
> > *(1) A performer, who is included in a performers list of a Local Health Board, shall make a declaration to that Local Health Board in writing within 7 days of its occurrence if the performer– …*
> > *(h) is informed by any licensing, regulatory or other body of the outcome of any investigation into the performer's professional conduct, and there is a finding against the performer;*
> > *(i) becomes the subject of any investigation into the performer's professional conduct by any licensing, regulatory or other body;*
>
> *Good Medical Practice 2013, which provides*
>
> > *1 Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.*
> >
> > *65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.*
> >
> > ***Openness and legal or disciplinary proceedings***
> >
> > *73 You must cooperate with formal inquiries and complaints procedures and must offer all relevant information while following the guidance in Confidentiality.'*

80. The position is that the Board was already aware that there were open GMC investigations against Dr Webberley by July 2017. Page 1 of the SBAR report dated 11 April 2017 includes the following passage:

'There have also been concerns raised by a number of sources relating to the management of patients being provided by services by Dr Webberley in relation to transgender issues and the prescribing of hormone treatments. These concerns have been elevated to the General Medical Council.'

81. They were mentioned in a letter from Dr Webberley's solicitors to the Health Board on 23 June 2017. In that letter Carbon Law Partners write:

'Our Client was first made aware of the Health Board's concerns via e-mail on Saturday, 22 April 2017. In this e-mail, our Client was provided with 176 pages of evidence and was advised that a Reference Panel hearing was to be held on Tuesday, 25 April 2017. Our Client was aware that the General Medical Council ("GMC") was investigating similar concerns and was cooperating with the GMC in order to alleviate those concerns. No notice was provided to our Client that the Health Board had initiated its own investigations.

…'

Dr N had previously referred these concerns to the GMC. On 24 March 2017, Dr N was advised by the GMC that *a full investigation had been opened*.'

82. In point of fact, there may be some doubt as to whether the letter was dated 24 March 2017. Dr N was at the material time the Deputy Medical Director and Deputy Responsible Officer of ABUHB. Dr N gave evidence on behalf of the GMC. He was cross-examined as follows:

'Q Then there is a question of the concerns in relation to the management of patients being provided services in relation to transgender issues and the prescribing of hormone treatments. Did you, in fact, and I think you did, at this stage, have something from Professor F?
A Yes, there had been a GMC referral and, as the responsible body, we would have been copied into that concern.

Q Exactly, because it says:
"These concerns have been elevated to the General Medical Council (GMC)."

Q So in April you were aware of that. I think there is somewhere the date, but you will know better than I probably, that Dr Webberley was notified on 20 March 2017 that the General Medical Council had decided to open an investigation and, as you rightly say, Dr OO would have received that notification as her responsible officer?

A That is right, yes.

Q Indeed, if it helps, the letter to Dr Webberley makes that clear, that Dr OO will be informed. So can we just then look a little further down, if you wouldn't mind, Dr N?
"It is also recommended that we re-iterate our increasing concern to the GMC, HIW and Welsh Government with a view to ensuring a co-ordinated response, including the involvement of relevant bodies outside Wales …"

…
A …

Q …
A …

Q … Just so we have page 637, just so that the tribunal knew what you knew, as it were, on 10 April, the second paragraph down:

"The most recent concern is a complaint to the General Medical Council by Professor I and Professor F."

Those are the transgender issues that you have referred to?
A Yes.'

83. It is therefore apparent that ABUHB had been informed of open GMC investigations in advance of the review, and that Dr Webberley was aware of that fact.

84. The question therefore arises as to whether she was under a duty in those circumstances by virtue of 'Regulation 9 of the National Health Service (Performers Lists) (Wales) Regulations 2004' and / or GMP to inform ABUHB after July 2017 about a matter of which she knew it was already cognisant. The Tribunal does not consider that the argument that she was under such a duty is sustainable. It finds therefore that Dr Webberley has no case to answer in respect of the allegation that she failed to advise ABUHB throughout the period of the review of open GMC investigations against her. It follows that paragraphs 21(b) and 22(b) of the Allegation fall.

85. Paragraph 22 does not fall, but that paragraph does not support paragraph 23 of the allegation which alleges dishonesty. Paragraph 23 is predicated on the basis of paragraph 21(b) and 22(b) of the Allegation which fall. Paragraph 23 of the Allegation therefore also falls.

Paragraphs 24 to 27

86. The submission is accepted in part. the Tribunal finds that Dr Webberley does not have a case to answer in respect of paragraphs 25, 26 and 27. However, there is a case to answer in respect of paragraph 24 of the Allegation.

Paragraph 24

87. Mr Stern made no particular submissions about this paragraph of the Allegation beyond observing that the date was confusing in that it appears to be cast in both the present and past tenses. No date is specified in the paragraph.

88. Mr Jackson by way of reply observed that a date specified in an indictment is not a material averment, unless it is an essential ingredient of the alleged offence, and cited authority in support of that proposition.

89. The Tribunal accepted Mr Jackson's argument and found that Dr Webberley has a case to answer in respect of Paragraph 24 of the Allegation.

Paragraph 25

90. This allegation stems from a passage in the SBAR Report dated 11 April 2017 drafted by Dr N and repeated in almost identical form in the Statement of Case dated 21 April 2017.

> *'Dr Helen Webberley is the principal provider of service on the website. In doing so the website states she states that she is supported by a number of individuals including* [XXX] *Dr SS, a consultant gastroenterologist, who advises on endocrinology, a number of counsellors, a speech and language therapist and others. Although the website based service offers hormonal treatments to children the website does not reference the input of accredited paediatricians Nor is there any reference to a child safeguarding policy on the website.'*

91. In view of the fact that Dr N set out what he contends he saw on the web site of Gender GP, there is evidence that it did state what he said it stated. Clearly that website was on line before 10 April 2017. The Tribunal noted the website page to which Mr Stern referred in his submissions, which included a 'quick link' to her safeguarding policies. However, there is no date on that website. It does not therefore comprehensively dispose of Dr N's record of the website page which he saw prior to preparing the SBAR report.

92. Paragraph 25 of the Allegation reads as follows:

> 25 As the principal provider of the Gender GP website, offering hormonal treatment to children, you failed to appropriately reference:
>
> a. the input of any accredited paediatrician/paediatric specialist;
>
> b. your safeguarding policy.

93. The Tribunal considered that paragraph 25 of the Allegation could be interpreted as an allegation that: (a) Dr Webberley was offering hormonal treatment to children; and (b) as

such, she had an obligation to reference the input the services of a paediatrician or a paediatric specialist and her safeguarding policy on the Gender GP website.

94. Mr Stern challenged whether Dr Webberley was under any duty *to reference any such services and / or her safeguarding policy in the Gender GP website*. Mr Jackson did not draw the Tribunal's attention to any duty under GMP in his opening nor in his written response to Mr Stern's submission of no case to answer, but he did rely on paragraph 70 of GMP when responding to Mr Stern's oral submissions.

95. The Tribunal considered paragraph 70 of GMP which states:

Communicating information

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

96. The Tribunal did not consider that paragraph 70 availed the GMC, in that there is no suggestion that the information published was not factual nor is there any evidence that it exploited or could exploit patients' vulnerability or lack of medical knowledge. Further, the Tribunal noted that there was no evidence before it that Dr Webberley had an obligation to include references to these matters. The Tribunal did not consider that it would be appropriate for it to contemplate whether any other paragraphs in GMP could be relied upon to impose a duty on Dr Webberley in these circumstances.

97. The Tribunal therefore accepted Mr Stern's application in relation to paragraph 25 of the Allegation. It found Dr Webberley has no case to answer in relation to paragraph 25.

Paragraph 26

98. The Tribunal accepted Mr Stern's application. The GMC did not offer any evidence in support of this allegation. The Tribunal therefore finds that Dr Webberley has no case to answer in respect of Paragraph 26 of the Allegation.

Paragraph 27

99. The Tribunal accepted Mr Stern's application. The Tribunal has found that Dr Webberley has no case to answer in respect of Paragraph 26 of the Allegation. It therefore follows that Paragraph 27 of the Allegation must fall; that is unless the words *'as set out in paragraph 26 above'*, may legitimately be severed from the paragraph. Mr Jackson made no application that they should be. Moreover, it is apparent that paragraph 27 of the Allegation reflects the alleged language on the alleged website to which Paragraph 26 of the Allegation refers. The Tribunal therefore finds that Dr Webberley has no case to answer in respect of Paragraph 27 of the Allegation.

ANNEX F – 04/10/2021 - Rule 34 Application to admit evidence

1. On Day 38 (20 September 2021), Mr Jackson QC, on behalf of the GMC, made an application for a bundle of evidence to be admitted, following the closure of the GMC's case and prior to Dr Webberley giving her evidence. An index of the evidence sought to be adduced was placed before the Tribunal. Mr Jackson told the Tribunal that the evidence, in the form of a short bundle, included:

- relevant Guidance (The Endocrine Society Review: News Release, BSPED Guideline, RCGP written evidence to House of Commons);
- a revised chronology of events relating to Patients A, B and C;
- Academic Papers (paper cited by Dr SS in Patient A's medical records – 'Verdonck, Gaethofs, Carels and de Zegher. Effect of lowdose testosterone treatment on craniofacial growth in boys with delayed puberty', and Dr Y's paper entitled 'Approach to the Patient: Transgender Youth: Endocrine Consideration')
- Gender GP documentation (Gender GP policy for Establishing Parental Responsibility, Dr Webberley's online CV for Gender GP, Dr SS's CV, the CVs of Gender GP Counsellors, and Patient A's unredacted consent form);
- Correspondence with Health Inspectorate Wales (HIW) and the GMC.

Submissions for the GMC

2. Mr Jackson said that the short bundle was provided to Dr Webberley's legal representatives on 17 September 2021. He explained that the GMC had prepared the bundle following the late disclosure of Dr Webberley's witness statements and other material by the defence. He explained that the GMC was obliged to undertake further work to prepare its case in response. Mr Jackson added that this was not new material and that Dr Webberley's legal representatives had already cross examined some of the GMC's witnesses on these matters. Mr Jackson said that the GMC was unable to produce this material sooner. Mr Jackson added that Dr Webberley would be assisted by having this evidence before her during her cross examination.

3. Mr Jackson submitted that no injustice would arise should the Tribunal allow his application, and that in any event he was entitled to cross examine Dr Webberley on these matters.

Submissions for the doctor

4. Mr Stern QC opposed the application in principle. He said it was disappointing that the GMC was seeking to introduce new matters at this stage of the proceedings. Mr Stern submitted that Dr Webberley had not had sufficient opportunity to consider this material, nor discuss it with her legal representatives. He said that the Tribunal should exercise caution when considering the application, stating that some of the material was not set out in the

Rule 7 letter issued to Dr Webberley nor the material produced as part of the main hearing bundle which is before this Tribunal.

5. Mr Stern submitted that it could not be right that the GMC is allowed to introduce new material after all of its witnesses had been cross examined, and when Dr Webberley was due to give her evidence. He said that the starting point is whether it is fair and relevant and submitted that it is not. he said that the GMC had been provided with all of the relevant material some time before the hearing commenced. He referred the Tribunal to case law in support of his submissions.

Tribunal's Decision

6. The Tribunal reminded itself that the admissibility of evidence is governed by Rule 34 of the 2004 Rules which provides:

> *'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.'*

7. It also had regard to Paragraph (1A) of Schedule 4 to The Medical Act 1983 as amended: Proceedings Before the Investigating Committee, Medical Practitioners Tribunals and Interim Orders Tribunals. That paragraph states as follows:

> *'The overriding objective of the General Council in making rules under this Schedule with respect to the procedure to be followed in proceedings before a Medical Practitioners Tribunal or an Interim Orders Tribunal, or with respect to the procedure to be followed by the Investigation Committee when deciding whether to give a warning under Section 35C6, is to secure that the Tribunal or Committee (as the case may be) deals with cases fairly and justly.'*

8. In considering the application, the Tribunal has taken into account the submissions made by both Counsel.

9. The Tribunal considers that Rule 34 reflects paragraph 1A of Schedule 4 as set out above.

10. The Tribunal took into account that Dr Webberley's witness statement and the reports of Dr W and Dr U were disclosed to the GMC relatively late in the day.

11. Having regard to the index the Tribunal considered that the material which the GMC requested to be admitted into evidence, was relevant and fair, and that it may assist the Tribunal in better understanding issues which it has to determine.

12. Taking the above into account, the Tribunal reached the conclusion that the material was relevant, and therefore, it was fair to admit it into evidence. It determined to grant Mr Jackson's application.

Schedule 1

23 September 2016 - Metformin 850mg 1 tablet 2 to 3 times a day 168 tablets