

**Dr Michael WEBBERLEY (2620107)**  
**DETERMINATION ON THE FACTS – 18/05/2022**

**Background**

1. Dr Webberley, a retired Consultant Physician, qualified with a MbChB from Dundee University in 1982. He became a Member of the Royal College of Physicians in 1985 and a Fellow of the Royal College of Physicians in 1998.
2. From 1994-2005, Dr Webberley worked as a Consultant Physician with an interest in Gastroenterology and Hepatology, in Worcester. He was the Trust Wide Clinical Lead for Endoscopy, Clinical Director for Gastroenterology and Associate Clinical Sub-Dean.
3. From 2005 to 2016, Dr Webberley held the position of Consultant Acute Physician with a subspecialty interest in Gastroenterology at Nevill Hall Hospital, Abergavenny. Dr Webberley was also Clinical Director for Medicine between 2006 – 2016, and Chief of Staff Acute Medicine between 2006 - 2009. He was Associate Divisional Director for Emergency Medicine between 2009 – 2016.
4. Dr Webberley faces 89 heads of charge spanning the period between 2017 and 2019. The Allegation concerns the care provided to 18 patients to whom Dr Webberley provided androgen treatment through a company known as Balance My Hormones ('BMH'); 7 transgender patients to whom Dr Webberley provided hormone treatment through a company known as 'GenderGP'; and allegations concerning Dr Webberley's operation and control of GenderGP. Included within the charges under all three heads, were a number of allegations of dishonesty. It is the GMC's case that Dr Webberley's fitness to practise is impaired by reason of misconduct.

Androgen Treatment for Male Patients - A-R (Paragraphs 1-63 of the Allegation)

5. Concerns were raised with the GMC regarding Dr Webberley and his provision of online services through BMH on 12 October 2018. The concerns were reported by a doctor who informed the GMC that he was the founder of a private clinic, Mens Health Clinic ('MHC'), specialising in the diagnosis and management of 'testosterone deficiency syndrome'. The reporting doctor advised the GMC that he had dealt with a number of patients in the preceding 10 months whose care had been transferred to him from BMH.

6. Many of these 'referral' patients had apparently raised concerns with the doctor at MHC in relation to the treatment provided by Dr Webberley; specifically, regarding a failure to hold 'face-to-face' consultations, or to conduct any examinations (either physical or mental) before inappropriately prescribing medications, a failure to provide adequate follow-up care, and poor-quality record-keeping.
7. Following receipt of medical records from MHC, and from Dr Webberley, the GMC obtained a number of witness statements from six former patients of Dr Webberley at BMH.
8. Following receipt of the witness statements, the GMC sought expert opinion evidence from Dr Richard Quinton, a practicing consultant physician and endocrinologist, working in the Northeast, as to the standard of care provided to 18 former patients of BMH who had either provided witness statements and/or in respect of whom medical records had been obtained from BMH and/or MHC.
9. Overall, Dr Quinton found that Dr Webberley's care and treatment of all 18 patients on which he could provide comment was seriously below the expected standard.

#### Transgender Patients, Patient S-Y (Paragraphs 64-82 of the Allegation)

10. In addition to the services Dr Webberley offered through BMH, he also provided care and treatment to a number of transgender patients as part of the services offered by 'GenderGP', a company of which Dr Webberley was then a director.
11. Dr Webberley's treatment included the prescribing of 'puberty blockers' to children and adolescent patients experiencing gender variance and with related anxiety and distress (gender dysphoria), and the prescribing of what have been previously referred to as 'cross-sex' hormones, that are now more commonly referred to as 'gender-affirming' hormones, to patients who wished to transition to their identified gender.
12. In several cases, Dr Webberley had taken over the care of these transgender patients from Dr Helen Webberley ('Dr HW'), a general practitioner ('GP') and Dr Webberley's wife, who was then also a director of GenderGP, an online advice and prescription service. In May 2017 Dr HW was made subject to interim restrictions on her practice, the details of which the Tribunal was not told but which it was informed about, by the GMC. These were not relevant to the issues to be determined by this Tribunal.
13. Patient S - In October 2018 a referral was received by the GMC from Dr Tracy Gardiner, Clinical Director of Cwn Taf Child and Adolescent Mental Health Services ('CAMHS' in Wales), raising concerns that Dr Webberley had prescribed hormones to Patient S without consulting with CAMHS or the Tavistock Gender Identity Development Service [GIDS] clinic, to which the patient had been referred.

14. Patient T - On 7 November 2017, the GMC received an online referral from Dr Dhrushil Patel, General Practitioner, in relation to Dr Webberley's treatment of Patient T, an 11-year-old patient of female birth gender, who identified as a male, and who was a patient of Dr Patel's at the Sunny Mead Surgery, Surrey, and who had been diagnosed by Dr HW as having gender dysphoria.

15. Dr Patel asserted that Dr Webberley had been writing prescriptions for Patient T on behalf of his wife, Dr HW, following the imposition of an interim order on her GMC registration that prevented her from doing so herself.

16. Dr Patel expressed concerns regarding the treatment of Patient T, as he was unsure of who exactly bore clinical responsibility for their treatment – whether Dr HW or Dr Webberley – and whether the relevant treating doctor had the necessary experience and/or authority to do so.

17. Patient U - On 11 September 2017, the GMC received a referral from Serena James, Community Mental Health Nurse at Ty Einon Centre in Swansea. Ms James alleged that Patient U had been prescribed testosterone gel by Dr Webberley under the GenderGP service, after only a telephone consultation and without having apparently made background checks regarding the patient's physical or mental health.

18. Patient U was described as a vulnerable 21-year-old with significant mental health problems. He was initially assessed by Dr HW, and he was then prescribed testosterone gel by Dr Webberley.

19. Patient V - On or about 23 July 2018, Dr Joanne Dangerfield, Consultant Paediatrician at the Countess of Chester NHS Hospital Foundation Trust saw Patient V, a nine-year-old who was born female but who now lived as a boy. She was assessing Patient V's headaches in her outpatient clinic and was concerned that Patient V was about to start hormone blocking treatment after consulting with GenderGP.

20. Dr Dangerfield was concerned that the necessary assessments required before starting a patient on hormone blockers may not have been carried out and also that Dr HW, who was subject to restrictions on her registration, appeared to have been involved in Patient V's care. Dr Dangerfield notified the GMC of her concerns.

21. Patient W - In September 2018, Patient W took his own life and there followed a coroner's inquest. As a result of media coverage, the GMC became aware that prior to Patient W's death he had received hormone treatment from GenderGP.

22. Patient X - On 26 February 2019, the GMC received an online referral from Dr Lucy Duckworth, a GP at Oldbury Health Centre, West Midlands, reporting that she had received a written request on 4 Feb 2019 from Dr Webberley, on behalf of his clinic, GenderGP, to enter into a shared-cared agreement for the prescription of cross hormone therapy and monitoring thereof by the NHS. Dr Duckworth also

reported that Dr Webberley had subsequently issued a private prescription for hormones to Patient X.

23. Dr Duckworth was concerned that Patient X had not been assessed face-to-face by Dr Webberley, but his contacts had been limited to emails, the completion of some online self-assessment questionnaires and one 30-minute telephone consultation with a counsellor.

24. Patient Y - On 1 March 2019, the GMC received an online referral from Dr Jamie Lewis (GP at Ashbourne Medical Practice, Derbyshire), stating that Patient Y had been receiving care for gender dysphoria from Dr Webberley via Gender GP and had been commenced on testosterone treatment.

25. Patient Y had asked his GP, Dr Lewis, to enter into a shared-care agreement with Dr Webberley and prescribe the hormones to him on the NHS. However, Dr Lewis was concerned at the lack of information from GenderGP, other than a shared care agreement template and the suggested medication to prescribe, and so he declined to sign and requested further information from Dr Webberley/GenderGP.

26. Dr Lewis was also concerned at the lack of apparent consultations with Patient Y with the exception of a 20 minute 'Skype' chat with a counsellor, followed by a 30-minute appointment with a nurse, after which a prescription for hormones was issued.

27. As a result of the various referrals the GMC instructed Dr Quinton and a second expert Dr Alanna Kierans, Specialist Clinical Psychologist, to provide an expert opinion on the standard of care provided to Patients S-Y. Both experts concluded that Dr Webberley's care in respect of all 7 transgender patients was either below or seriously below the expected standard.

#### Gender GP (Paragraphs 83 -89 of the Allegation)

28. During the relevant period, Dr Webberley together with Dr HW operated and controlled the company known as 'GenderGP', through which the doctors offered their services to transgender patients.

29. The company was formally registered at UK Companies House as 'Online GP Services Ltd' and was incorporated on 18 November 2014. Dr HW was listed at Companies House as a Director of the company from its incorporation and Dr Webberley joined the company as a director on 20 January 2017.

30. It is alleged that in May 2019, the 'governance page' of the GenderGP website included the following statement:

*"All medical advice and prescriptions are provided by doctors who work outside the UK. Due to concerns about transphobia amongst some UK institutions and historic cases of regulatory investigation of UK doctors who offer gender-affirming care, we feel that gender specialists from countries that understand the informed consent model of care are safer for you as a*

*patient, and for the doctors that provide your care. All doctors who provide medical services are regulated in their own country and have necessary regulation, training, regulation, and insurance to cover their work.”*

31. Further, it is alleged that Dr Webberley, in adopting the operating method of GenderGP as described on the website ‘governance page’, was seeking to circumvent the regulatory framework in the United Kingdom particularly in relation to the Care Quality Commission (‘CQC’) and Health Inspectorate Wales (‘HIW’).

32. Furthermore, it is alleged that in November 2018, the only general practitioner at GenderGP was Dr HW who was at that time subject to an interim order of suspension and there were no other GPs practising at GenderGP at that time. In these circumstances it is alleged that Dr Webberley, knowing that Dr HW was unable to participate in the work of GenderGP, and that there were no other GPs practising at GenderGP, was acting dishonestly in retaining the name and continuing to represent the company as ‘GenderGP’.

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

33. On 9 March 2022, at the commencement of the hearing, Ms Rosalind Scott-Bell, Counsel on behalf of Dr Webberley, made an application to adjourn the hearing, pursuant to Rule 29(2) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (‘the Rules’). Mr Simon Jackson QC, on behalf of the GMC opposed the application. The Tribunal rejected the application. Its written decision can be found at Annex A.

34. On Day 11 of the hearing, 23 March 2022, having rejected the application to adjourn proceedings, the Tribunal went on to consider proof of service and an application by the GMC to proceed in Dr Webberley’s absence. Proof of service was conceded by Ms Scott-Bell on behalf of Dr Webberley. Ms Scott-Bell had previously informed the Tribunal that whilst she was instructed to oppose any application to proceed in Dr Webberley’s absence, he would be unrepresented thereafter should the application fail. The Tribunal granted the application to proceed in Dr Webberley’s absence. The Tribunal’s written decision can be found at Annex B.

35. On 25 March 2022, the Tribunal handed down its determination to proceed in Dr Webberley’s absence. Following this, Ms Scott-Bell made an application to adjourn the hearing, pursuant to Rule 29(2) of the Rules. She made her application to adjourn in order to consider whether there were grounds to pursue an application for judicial review before the Administrative Court. This application was opposed by the GMC. The Tribunal rejected the application. Its written decision can be found at Annex C.

36. After going into camera and during the course of deliberations, the Tribunal identified a number of apparent minor errors in the Allegation which it considered should be amended and could be amended without injustice. Prior to handing down the determination, the Tribunal invited representations as to the proposed amendments and no objections were raised. Accordingly, the Tribunal amended the Allegation of its own motion pursuant to Rule 17(6) of the Rules as appears in the

Tribunals Overall Determination on the Facts herein at paragraphs 6a, 37a, 48ai and 72ci.

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

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

#### Patient A

1. Between 12 April 2017 and on or around 3 August 2018, you failed to provide good clinical care to Patient A in that you:
  - a. did not hold a consultation with Patient A; **To be determined**
  - b. did not elicit an adequate medical history from Patient A, in that you did not elicit details of:
    - i. sexual symptoms; **To be determined**
    - ii. non-sexual symptoms; **To be determined**
    - iii. answers to general health questions concerning the presenting complaint; **To be determined**
  - c. did not perform any physical or mental health examination; **To be determined**
  - d. inappropriately diagnosed Patient A with hypogonadism in that:
    - i. the diagnosis was not supported by laboratory results; **To be determined**
    - ii. you failed to consider any alternative diagnosis; **To be determined**
  - e. prescribed testosterone, Human Chorionic Gonadotropin ('hCG') and anastrozole which was:
    - i. not clinically indicated; **To be determined**
    - ii. unsafe; **To be determined**
    - iii. not recognised as therapeutic practice in medicine; **To be determined**
  - f. did not conduct tests adequately; **To be determined**

- g. inappropriately relied on non-medically trained members of staff to review results of Patient A's blood tests;  
**To be determined**
  - h. did not communicate at all with Patient A during the course of his treatment; **To be determined**
  - i. did not provide adequate follow up care in that you failed to arrange a follow-up consultation with Patient A after treatment had commenced; **To be determined**
  - j. did not respond to follow-up blood tests which indicated over-treatment **To be determined**
2. The Participation Agreement & Informed Consent Form and the Consent for Testosterone Replacement Therapy Form ('the Consent Forms') provided to Patient A stated that:
- a. the higher limit of normal testosterone range was 40 nmol/L;  
**To be determined**
  - b. untreated hypogonadism can increase the risk of:
    - i. heart disease; **To be determined**
    - ii. Alzheimer's disease; **To be determined**
    - iii. premature death; **To be determined**
  - c. the treatment provided was 'TRT' (testosterone replacement therapy). **To be determined**
3. You knew that the information in the Consent Form was untrue as:
- a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **To be determined**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **To be determined**
    - ii. Alzheimer's disease; **To be determined**
    - iii. premature death; **To be determined**
  - c. the treatment to be provided would increase testosterone above normal limits and was not TRT. **To be determined**

4. Your conduct as set out at paragraph 2 was dishonest by reason of paragraph 3. **To be determined**
5. You did not obtain informed consent from Patient A for treatment you provided in that:
  - a. you failed to counter-sign the Consent Forms;  
**To be determined**
  - b. the Consent Forms contained statements which were untrue.  
**To be determined**

Patient B

6. Between 15 June 2017 and 17 September 2018, you failed to provide good clinical care to Patient B in that you:
  - a. did not hold a consultation with Patient B; **To be determined**
  - b. did not yourself elicit an adequate medical history from Patient HO, in that you did not elicit details of:
    - i. sexual symptoms; **To be determined**
    - ii. non-sexual symptoms; **To be determined**
    - iii. answers to general health questions concerning the presenting complaint; **To be determined**
    - iv. details of his treatment for high blood pressure with doxazosin; **To be determined**
  - c. did not perform any physical or mental health examination of Patient B; **To be determined**
  - d. inappropriately diagnosed Patient B with hypogonadism in that:
    - i. the diagnosis was not supported by laboratory results;  
**To be determined**
    - ii. you failed to consider any alternative diagnosis;  
**To be determined**
  - e. prescribed testosterone which was:
    - i. not clinically indicated; **To be determined**
    - ii. unsafe; **To be determined**

- f. did not conduct tests adequately; **To be determined**
  - g. did not review Patient B's:
    - i. laboratory test results; **To be determined**
    - ii. medication; **To be determined**
  - h. inappropriately relied on a non-medically trained member of staff to review Patient B's laboratory results;  
**To be determined**
  - i. did not adequately communicate with Patient B in that you:
    - i. delegated communications to non-medically trained members of staff when it was inappropriate to do so;  
**To be determined**
    - ii. failed to maintain regular correspondence;  
**To be determined**
  - j. did not provide adequate follow up care in that you relied entirely upon email communication between Patient B and non-clinical facilitators. **To be determined**
7. The Consent Forms provided to Patient B stated that:
- a. the higher limit of normal testosterone range was 40 nmol/L;  
**To be determined**
  - b. untreated hypogonadism can increase the risk of:
    - i. heart disease; **To be determined**
    - ii. Alzheimer's disease; **To be determined**
    - iii. premature death; **To be determined**
  - c. the treatment provided was TRT. **To be determined**
8. You knew that the information in the Consent Forms was untrue as:
- a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **To be determined**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:

- i. heart disease; **To be determined**
    - ii. Alzheimer's disease; **To be determined**
    - iii. premature death; **To be determined**
  - c. the treatment to be provided would increase testosterone above normal limits and was not TRT. **To be determined**
9. Your conduct as set out at paragraph 7 was dishonest by reason of paragraph 8. **To be determined**
10. You did not obtain informed consent from Patient B for treatment you provided in that:
- a. you failed to counter-sign the Consent Forms;  
**To be determined**
  - b. the Consent Forms contained statements which were untrue.  
**To be determined**

#### Patient C

11. Between 26 July 2017 and 29 June 2018, you failed to provide good clinical care to Patient C in that you:
- a. consulted with Patient C on 17 August 2017 and failed to:
    - i. elicit an adequate medical history in that you:
      - 1. relied upon details obtained by a non-medically trained member of staff; **To be determined**
      - 2. failed to elicit details of sexual symptoms;  
**To be determined**
      - 3. failed to elicit details of non-sexual symptoms;  
**To be determined**
      - 4. failed to ask general health questions concerning the presenting complaint;  
**To be determined**
  - b. did not perform any physical or mental health examination;  
**To be determined**
  - c. inappropriately diagnosed Patient C with hypogonadism requiring long term treatment in that:

- i. the diagnosis was not supported by laboratory results;  
**To be determined**
    - ii. you failed to consider any alternative diagnosis;  
**To be determined**
  - d. prescribed testosterone, hCG and anastrozole which was:
    - i. not clinically indicated; **To be determined**
    - ii. unsafe; **To be determined**
    - iii. not recognised as therapeutic practice in medicine;  
**To be determined**
  - e. did not conduct tests adequately; **To be determined**
  - f. did not review any test results performed during the course of Patient C's treatment; **To be determined**
  - g. did not adequately communicate with Patient C;  
**To be determined**
  - h. did not provide adequate follow up care in that you failed to arrange a follow-up consultation with Patient C after treatment had commenced. **To be determined**
- 12. The Consent Forms provided to Patient C stated that:
  - a. the higher limit of normal testosterone range was 40 nmol/L;  
**To be determined**
  - b. untreated hypogonadism can increase risk of:
    - i. heart disease; **To be determined**
    - ii. Alzheimer's disease; **To be determined**
    - iii. premature death; **To be determined**
  - c. the treatment provided was TRT. **To be determined**
- 13. You knew that the information in the Consent Forms was untrue as:
  - a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **To be determined**

- b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **To be determined**
    - ii. Alzheimer's disease; **To be determined**
    - iii. Premature death; **To be determined**
  - c. the treatment provided increased testosterone above normal limits and was not TRT. **To be determined**
14. Your conduct as set out at paragraph 12 was dishonest by reason of paragraph 13. **To be determined**
15. You did not obtain informed consent from Patient C for treatment you provided in that: **To be determined**
- a. you failed to counter-sign the Consent Forms;  
**To be determined**
  - b. the Consent Forms contained statements which were untrue.  
**To be determined**

Patient D

16. Between September 2017 and September 2018, you failed to provide good clinical care to Patient D in that you:
- a. did not hold a consultation with Patient D; **To be determined**
  - b. did not elicit an adequate medical history from Patient D, in that you did not elicit details of:
    - i. sexual symptoms; **To be determined**
    - ii. non-sexual symptoms; **To be determined**
    - iii. answers to general health questions concerning the complaint; **To be determined**
  - c. did not perform any physical or mental health examination;  
**To be determined**
  - d. inappropriately diagnosed Patient D with hypogonadism in that:
    - i. the diagnosis was not supported by laboratory results;  
**To be determined**

- ii. you failed to consider any alternative diagnosis;  
**To be determined**
- e. prescribed testosterone, hCG, anastrozole and mesterolone which was:
  - i. not clinically indicated; **To be determined**
  - ii. unsafe; **To be determined**
- f. did not conduct tests adequately in that you failed to:
  - i. specify the conditions under which blood should be drawn; **To be determined**
  - ii. check Patient D's full blood count for haematocrit until five months after starting treatment; **To be determined**
- g. did not accurately interpret test results on 4 September 2017 when they showed evidence of:
  - i. anabolic steroid abuse; **To be determined**
  - ii. clinically significant pituitary mass lesion;  
**To be determined**
  - iii. acute kidney injury; **To be determined**
  - iv. intake of undeclared creatine supplements;  
**To be determined**
- h. did not accurately interpret repeat test results on 15 February 2018 when they showed evidence of that as set out at paragraph 16.g above; **To be determined**
- i. did not reduce Patient D's medication following receipt of test results as set out at paragraphs 16.g – h above;  
**To be determined**
- j. did not adequately communicate with Patient D in that you delegated communications to non-medically trained members of staff when it was inappropriate to do so; **To be determined**
- k. did not provide adequate follow up care in that you:
  - i. failed to arrange a follow-up consultation with Patient D after treatment had commenced; **To be determined**

- ii. relied upon email communication between Patient D and non-clinical facilitators. **To be determined**
- 17. The Consent Forms provided to Patient D stated that:
  - a. the higher limit of normal testosterone range was 40 nmol/L; **To be determined**
  - b. untreated hypogonadism can increase risk of:
    - i. heart disease; **To be determined**
    - ii. Alzheimer's disease; **To be determined**
    - iii. premature death; **To be determined**
  - c. the treatment provided was TRT; **To be determined**
  - d. Patient D will not take 'any type of anabolic steroid'. **To be determined**
- 18. You knew that the information in the Consent Forms was untrue as:
  - a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **To be determined**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **To be determined**
    - ii. Alzheimer's disease; **To be determined**
    - iii. premature death; **To be determined**
  - c. the treatment provided increased testosterone above normal limits and was not TRT; **To be determined**
  - d. you prescribed or arranged to be prescribed anabolic steroids to Patient D. **To be determined**
- 19. Your conduct as set out at paragraph 17 was dishonest by reason of paragraph 18. **To be determined**
- 20. You did not obtain informed consent from Patient D for treatment you provided in that:

- a. you failed to counter-sign the Consent Forms;  
**To be determined**
- b. the Consent Forms contained statements which were untrue.  
**To be determined**

Patient E

21. Between September 2017 and September 2018, you failed to provide good clinical care to Patient E in that you:
- a. did not hold a consultation with Patient E; **To be determined**
  - b. did not elicit an adequate medical history from Patient E, in that you did not elicit details of:
    - i. underlying causes of Patient E's abnormal ALT level;  
**To be determined**
    - ii. Patient E's previous use of anabolic steroids;  
**To be determined**
  - c. did not perform any physical or mental health examination;  
**To be determined**
  - d. inappropriately diagnosed Patient E with hypogonadism in that:
    - i. the diagnosis was contrary to laboratory results which showed normal gonadal function; **To be determined**
    - ii. you failed to consider any alternative diagnosis;  
**To be determined**
  - e. prescribed testosterone, hCG and mesterolone which was:
    - i. not clinically indicated; **To be determined**
    - ii. unsafe; **To be determined**
  - f. did not conduct tests adequately; **To be determined**
  - g. did not review and adjust Patient E's treatment plan following concerns raised regarding symptoms of over-treatment of testosterone; **To be determined**
  - h. did not adequately communicate with Patient E in that you delegated communications to non-medically trained members of staff when it was inappropriate to do so; **To be determined**

- i. did not maintain an adequate record throughout the period of treatment of Patient E. **To be determined**
22. The Consent Forms provided to Patient E stated that:
- a. the higher limit of normal testosterone range was 40 nmol/L; **To be determined**
  - b. untreated hypogonadism can increase the risk of:
    - i. heart disease; **To be determined**
    - ii. Alzheimer's disease; **To be determined**
    - iii. premature death; **To be determined**
  - c. the treatment provided was TRT; **To be determined**
  - d. Patient E will not take 'any type of anabolic steroid'. **To be determined**
23. You knew that the information in the Consent Forms was untrue as:
- a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **To be determined**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **To be determined**
    - ii. Alzheimer's disease; **To be determined**
    - iii. premature death; **To be determined**
  - c. the treatment to be provided would increase testosterone above normal limits and was not TRT; **To be determined**
  - d. you prescribed, or arranged to be prescribed, anabolic steroids to Patient E. **To be determined**
24. Your conduct as set out at paragraph 22 was dishonest by reason of paragraph 23. **To be determined**
25. You did not obtain informed consent from Patient E for treatment you provided in that:

- a. you failed to counter-sign the Consent Forms;  
**To be determined**
- b. the Consent Forms contained statements which were untrue.  
**To be determined**

Patient F

26. Between October 2017 and December 2018, you failed to provide good clinical care to Patient F in that you:
- a. did not hold a consultation with Patient F; **To be determined**
  - b. did not elicit an adequate medical history from Patient F, in that you did not elicit details of:
    - i. sexual symptoms; **To be determined**
    - ii. non-sexual symptoms; **To be determined**
    - iii. answers to general health questions concerning the presenting complaint; **To be determined**
  - c. did not perform any physical or mental health examination of Patient F; **To be determined**
  - d. prescribed testosterone:
    - i. which was inappropriate in that it was:
      - 1. not clinically indicated; **To be determined**
      - 2. double the typical physiological replacement dose; **To be determined**
  - e. did not conduct / arrange all necessary tests before prescribing medication to Patient F; **To be determined**
  - f. did not adequately explain to Patient F how to safely administer the prescribed medication; **To be determined**
  - g. did not review Patient F's treatment plan; **To be determined**
  - h. did not adequately communicate with Patient F;  
**To be determined**
  - i. did not provide adequate follow up care; **To be determined**

- j. did not obtain informed consent from Patient F in that you did not explain the risks and benefits of proposed treatment;  
**To be determined**
- k. did not maintain adequate medical records throughout the period of treatment of Patient F. **To be determined**

Patient G

27. Between 6 December 2017 and 23 April 2018, you failed to provide good clinical care to Patient G in that you:
- a. did not hold a consultation with Patient G; **To be determined**
  - b. did not elicit an adequate medical history from Patient G, in that you did not elicit details of:
    - i. sexual symptoms; **To be determined**
    - ii. non-sexual symptoms; **To be determined**
    - iii. answers to general health questions concerning the presenting complaint; **To be determined**
    - iv. Patient G's alcohol intake; **To be determined**
  - c. did not perform any physical or mental health examination;  
**To be determined**
  - d. inappropriately diagnosed Patient G with hypogonadism in that:
    - i. the diagnosis was not supported by laboratory results;  
**To be determined**
    - ii. you failed to consider any alternative diagnosis;  
**To be determined**
  - e. prescribed unlicensed testosterone cream and anastrozole which was:
    - i. not clinically indicated; **To be determined**
    - ii. unsafe; **To be determined**
    - iii. not recognised as therapeutic practice in medicine;  
**To be determined**

- f. did not conduct tests adequately in that you failed to check Patient G's full blood count; **To be determined**
- g. did not identify that repeat blood tests were contrary to your diagnosis of hypogonadism; **To be determined**
- h. did not adequately communicate with Patient G; **To be determined**
- i. did not provide adequate follow up care in that you:
  - i. failed to arrange a follow-up consultation with Patient G after treatment had commenced; **To be determined**
  - ii. delegated communications with Patient G to non-medically trained members of staff. **To be determined**

28. The Consent Forms provided to Patient G stated that:

- a. the higher limit of normal testosterone range was 40 nmol/L; **To be determined**
- b. untreated hypogonadism can increase the risk of:
  - i. heart disease; **To be determined**
  - ii. Alzheimer's disease; **To be determined**
  - iii. premature death; **To be determined**
- c. the treatment provided was TRT. **To be determined**

29. You knew that the information in the Consent Form was untrue as:

- a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **To be determined**
- b. there was a lack of evidence that untreated hypogonadism increased the risk of:
  - i. heart disease; **To be determined**
  - ii. Alzheimer's disease; **To be determined**
  - iii. premature death; **To be determined**
- c. the treatment to be provided would increase testosterone above normal limits and was not TRT. **To be determined**

30. Your conduct as set out at paragraph 28 was dishonest by reason of paragraph 29. **To be determined**
31. You did not obtain informed consent from Patient G for treatment you provided in that:
- a. you failed to counter-sign the Consent Forms;  
**To be determined**
  - b. the Consent Forms contained statements which were untrue.  
**To be determined**

Patient H

32. Between 28 December 2017 and 18 May 2018, you failed to provide good clinical care to Patient H in that you:
- a. consulted with Patient H on 6 January 2018 and failed to:
    - i. elicit an adequate medical history in that you did not:
      - 1. elicit details of sexual symptoms:  
**To be determined**
      - 2. elicit details of non-sexual symptoms;  
**To be determined**
      - 3. ask general health questions concerning the presenting complaint; **To be determined**
  - b. did not perform any physical or mental health examination;  
**To be determined**
  - c. inappropriately diagnosed Patient H with hypogonadism in that:
    - i. the diagnosis was not supported by laboratory results;  
**To be determined**
    - ii. you failed to consider any alternative diagnosis;  
**To be determined**
  - d. prescribed testosterone propionate, hCG and anastrozole:
    - i. despite the fact that Patient H had expressly stated he did not want to compromise his fertility;  
**To be determined**

- ii. which was:
    - 1. not clinically indicated; **To be determined**
    - 2. unsafe; **To be determined**
    - 3. not recognised as therapeutic practice in medicine; **To be determined**
  - e. did not conduct tests adequately in that you failed to:
    - i. specify the conditions under which blood should be drawn; **To be determined**
    - ii. arrange a repeat check of Patient H's full blood count; **To be determined**
  - f. did not identify that subsequent test results evidenced signs of over treatment of testosterone; **To be determined**
  - g. did not adequately communicate with Patient H in that you failed to maintain regular correspondence; **To be determined**
  - h. did not provide adequate follow up care in that you failed to arrange a follow-up consultation with Patient H after treatment had commenced. **To be determined**
33. The Consent Forms provided to Patient H stated that:
- a. the higher limit of normal testosterone range was 40 nmol/L; **To be determined**
  - b. untreated hypogonadism can increase the risk of:
    - i. heart disease; **To be determined**
    - ii. Alzheimer's disease; **To be determined**
    - iii. premature death; **To be determined**
  - c. the treatment provided was TRT. **To be determined**
34. You knew that the information in the Consent Forms was untrue as:
- a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **To be determined**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:

- i. heart disease; **To be determined**
    - ii. Alzheimer's disease; **To be determined**
    - iii. premature death; **To be determined**
  - c. the treatment to be provided would increase testosterone above normal limits and was not TRT. **To be determined**
35. Your conduct as set out at paragraph 33 was dishonest by reason of paragraph 34. **To be determined**
36. You did not obtain informed consent from Patient H for treatment you provided in that:
- a. you failed to counter-sign the Consent Forms;  
**To be determined**
  - b. the Consent Forms contained statements which were untrue.  
**To be determined**

Patient I

37. Between 5 January 2018 and 23 March 2018, you failed to provide good clinical care to Patient I in that you:
- a. consulted with Patient I on 31 January 2018 and failed to:
    - i. elicit an adequate medical history in that you:
      - 1. relied upon details obtained by a non-medically trained member of staff; **To be determined**
      - 2. failed to elicit details of sexual symptoms;  
**To be determined**
      - 3. failed to elicit details of non-sexual symptoms;  
**To be determined**
    - ii. ask general health questions concerning the presenting complaint; **To be determined**
  - b. did not perform any physical or mental health examination;  
**To be determined**
  - c. inappropriately diagnosed Patient I with hypogonadism in that you failed to consider any:

- i. alternative diagnosis; **To be determined**
  - ii. likelihood that Patient I was seeking medication to build muscle mass rather than for therapeutic use; **To be determined**
- d. prescribed testosterone, anastrozole and mesterolone which was:
  - i. not clinically indicated; **To be determined**
  - ii. unsafe; **To be determined**
  - iii. not recognised as therapeutic practice in medicine; **To be determined**
- e. did not order any tests for Patient I:
  - i. before commencing treatment; **To be determined**
  - ii. during treatment; **To be determined**
- f. did not adequately communicate with Patient I in that you delegated communications to non-medically trained members of staff when it was inappropriate to do so; **To be determined**
- g. did not provide adequate follow up care in that you:
  - i. failed to arrange a follow-up consultation with Patient I after treatment had commenced; **To be determined**
  - ii. relied upon email communication between Patient I and non-clinical facilitators; **To be determined**
- h. did not obtain informed consent from Patient I in that you failed to advise Patient I of:
  - i. the lack of evidence for therapeutic use for men with Patient I's presenting condition of the medication prescribed as set out at paragraph 37d; **To be determined**
  - ii. the fact that the long-term risks associated with mesterolone treatment were unknown; **To be determined**
  - iii. the risks associated with testosterone treatment; **To be determined**

- iv. the risks associated with anastrozole treatment;  
**To be determined**

Patient J

38. Between 8 February 2018 and 7 November 2018, you failed to provide good clinical care to Patient J in that you:
- a. did not hold a consultation with Patient J; **To be determined**
  - b. did not elicit an adequate medical history, in that you failed to elicit details of:
    - i. history of anabolic steroid use; **To be determined**
    - ii. post cycle therapy; **To be determined**
  - c. did not perform any physical or mental health examination of Patient J; **To be determined**
  - d. inappropriately diagnosed Patient J with hypogonadism in that:
    - i. you failed to consider any alternative diagnosis; **To be determined**
    - ii. laboratory evidence did not support a diagnosis of hypogonadism; **To be determined**
    - iii. you failed to adequately investigate whether Patient J was seeking the medication primarily for the purpose of muscle-building, rather than for any clinical need; **To be determined**
  - e. prescribed testosterone, hCG, exemestane and mesterolone which was:
    - i. not clinically-indicated; **To be determined**
    - ii. unsafe; **To be determined**
  - f. did not arrange all necessary tests for Patient J before reaching a diagnosis, including full blood count; **To be determined**
  - g. did not review Patient J's treatment plan when subsequent test results evidenced signs of over treatment of testosterone and hCG; **To be determined**

- h. did not adequately communicate with Patient J in that you failed to maintain regular correspondence;
  - i. did not maintain adequate medical records throughout the period of treatment of Patient J. **To be determined**
39. The Consent Forms provided to Patient J stated that:
- a. the higher limit of normal testosterone range was 40 nmol/L; **To be determined**
  - b. untreated hypogonadism can increase the risk of:
    - i. heart disease; **To be determined**
    - ii. Alzheimer's disease; **To be determined**
    - iii. premature death; **To be determined**
  - c. the treatment provided was TRT ; **To be determined**
  - d. Patient J will not take 'any type of anabolic steroid'. **To be determined**
40. You knew that the information in the Consent Forms was untrue as:
- a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **To be determined**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **To be determined**
    - ii. Alzheimer's disease; **To be determined**
    - iii. premature death; **To be determined**
  - c. the treatment to be provided would increase testosterone above normal limits and was not TRT; **To be determined**
  - d. you prescribed, or arranged to be prescribed, anabolic steroids to Patient J. **To be determined**
41. Your conduct as set out at paragraph 39 was dishonest by reason of paragraph 40. **To be determined**

42. You did not obtain informed consent from Patient J for treatment you provided in that:
- a. you failed to counter-sign the Consent Forms;  
**To be determined**
  - b. the Consent Forms contained statements which were untrue.  
**To be determined**

Patient K

43. Between 13 March 2018 and 7 September 2018, you failed to provide good clinical care to Patient K in that you:
- a. consulted with Patient K on 21 March 2018 and you did not elicit an adequate medical history in that you:
    - i. inappropriately relied upon details obtained by a non-medically trained member of staff; **To be determined**
    - ii. failed to elicit details of sexual symptoms;  
**To be determined**
    - iii. failed to elicit details of non-sexual symptoms;  
**To be determined**
    - iv. failed to elicit details of Patient K's recent use of Clomiphene; **To be determined**
    - v. failed to recognise the degree of hypogonadal insufficiency based upon Patient K's previous diagnosis of testicular cancer; **To be determined**
  - b. did not perform any physical or mental health examination;  
**To be determined**
  - c. diagnosed hypogonadism without identifying the correct sub-type of compensated primary hypogonadism;  
**To be determined**
  - d. prescribed testosterone, hCG and mesterolone which was:
    - i. not clinically-indicated; **To be determined**
    - ii. unsafe; **To be determined**

- e. did not review and adjust Patient K's prescribed medication when laboratory results revealed excessively high testosterone levels; **To be determined**
  - f. did not adequately arrange repeat tests in that you failed to:
    - i. specify the conditions under which blood should be drawn; **To be determined**
    - ii. check Patient K's full blood count; **To be determined**
  - g. did not adequately communicate with Patient K in that you delegated communications to non-medically trained members of staff when it was not appropriate to do so; **To be determined**
  - h. did not provide adequate follow up care in that you relied entirely upon email communication between Patient K and non-clinical facilitators; **To be determined**
  - i. did not maintain an adequate record throughout the period of treatment of Patient K. **To be determined**
44. The Consent Forms provided to Patient K stated that:
- a. the higher limit of normal testosterone range was 40 nmol/L; **To be determined**
  - b. untreated hypogonadism can increase the risk of:
    - i. heart disease; **To be determined**
    - ii. Alzheimer's disease; **To be determined**
    - iii. premature death; **To be determined**
  - c. the treatment provided was TRT; **To be determined**
  - d. Patient K will not take 'any type of anabolic steroid'. **To be determined**
45. You knew that the information in the Consent Forms was untrue as:
- a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **To be determined**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:

- i. heart disease; **To be determined**
  - ii. Alzheimer's disease; **To be determined**
  - iii. premature death; **To be determined**
  - c. the treatment to be provided would increase testosterone above normal limits and was not TRT; **To be determined**
  - d. you prescribed, or arranged to be prescribed, anabolic steroids to Patient K. **To be determined**
46. Your conduct as set out at paragraph 44 was dishonest by reason of paragraph 45. **To be determined**
47. You did not obtain informed consent from Patient K for treatment you provided in that:
- a. you failed to counter-sign the Consent Forms; **To be determined**
  - b. the Consent Forms contained statements which were untrue. **To be determined**

Patient L

48. Between 8 March 2018 and 9 October 2018, you failed to provide good clinical care to Patient L in that you:
- a. consulted with Patient L on 8 March 2018 and failed to:
    - i. elicit an adequate medical history in that you did not elicit details of Patient C's;
      - 1. history of anabolic steroid use; **To be determined**
      - 2. post-cycle therapy; **To be determined**
    - ii. document basic clinical observations; **To be determined**
    - iii. adequately explain to Patient L:
      - 1. how to safely administer testosterone injections; **To be determined**
      - 2. the risks associated with proposed treatment options; **To be determined**

- b. did not estimate Patient L's testicular volumes as part of a physical examination; **To be determined**
- c. inappropriately diagnosed Patient L with hypogonadism in that:
  - i. clinical evidence for hypogonadism was inadequately investigated; **To be determined**
  - ii. you failed to consider any alternative diagnosis; **To be determined**
  - iii. laboratory evidence did not support a diagnosis of hypogonadism; **To be determined**
- d. prescribed testosterone, hCG and mesterolone which was:
  - i. not clinically indicated; **To be determined**
  - ii. unsafe; **To be determined**
- e. did not adequately communicate with Patient L in that you:
  - i. failed to maintain regular contact during the course of Patient L's treatment; **To be determined**
  - ii. delegated communications with Patient L to non-medically trained staff when it was not appropriate to do so; **To be determined**
- f. did not review during treatment:
  - i. feedback from Patient L regarding his treatment; **To be determined**
  - ii. Patient L's laboratory results; **To be determined**
- g. did not provide any oversight to non-medical members of staff advising Patient L on clinical matters during his treatment; **To be determined**
- h. following receipt of results which indicated treatment was ineffective, did not:
  - i. suspend or reduce medication; **To be determined**
  - ii. review the original diagnosis; **To be determined**

- i. did not arrange all necessary tests for Patient L;  
**To be determined**
  - j. did not maintain adequate medical records throughout the period of treatment of Patient L. **To be determined**
49. The Consent Forms provided to Patient L stated that:
- a. the higher limit of normal testosterone range was 40 nmol/L;  
**To be determined**
  - b. untreated hypogonadism can increase the risk of:
    - i. heart disease; **To be determined**
    - ii. Alzheimer's disease; **To be determined**
    - iii. premature death; **To be determined**
  - c. the treatment provided was TRT; **To be determined**
  - d. Patient L will not take 'any type of anabolic steroid'.  
**To be determined**
50. You knew that the information in the Consent Form was untrue as:
- a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **To be determined**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **To be determined**
    - ii. Alzheimer's disease; **To be determined**
    - iii. Premature death; **To be determined**
  - c. the treatment to be provided would increase testosterone above normal limits and was not TRT; **To be determined**
  - d. you prescribed, or arranged to be prescribed, anabolic steroids to Patient L. **To be determined**
51. Your conduct as set out at paragraph 49 was dishonest by reason of paragraph 50. **To be determined**

52. You did not obtain informed consent from Patient L for treatment you provided in that:
- a. you failed to counter-sign the Consent Forms;  
**To be determined**
  - b. the Consent Forms contained statements which were untrue.  
**To be determined**

Patient M

53. Between March 2018 and 31 August 2018, you failed to provide good clinical care to Patient M in that you:
- a. consulted with Patient M on 24 April 2018 and failed to elicit an adequate medical history in that you:
    - i. relied upon details obtained by a non-medically trained member of staff; **To be determined**
    - ii. failed to elicit details of sexual symptoms;  
**To be determined**
    - iii. failed to elicit details of non-sexual symptoms;  
**To be determined**
  - b. did not perform any physical or mental health examination;  
**To be determined**
  - c. inappropriately diagnosed Patient M with hypogonadism in that:
    - i. the diagnosis was not supported by laboratory results;  
**To be determined**
    - ii. you failed to consider any alternative diagnosis;  
**To be determined**
    - iii. you failed to refer to evidence which suggested Patient M was seeking medication for androgen abuse;  
**To be determined**
  - d. prescribed testosterone and mesterolone which was:
    - i. not clinically indicated; **To be determined**
    - ii. unsafe; **To be determined**
  - e. did not conduct tests adequately in that you failed to:

- i. specify the conditions under which blood should be drawn; **To be determined**
    - ii. check Patient M's full blood count for haematocrit; **To be determined**
  - f. did not review Patient M's treatment plan when subsequent test results evidenced signs of over treatment of testosterone; **To be determined**
  - g. did not adequately communicate with Patient M in that you delegated communications to non-medically trained members of staff when it was inappropriate to do so. **To be determined**
54. The Consent Forms provided to Patient M stated that:
- a. the higher limit of normal testosterone range was 40 nmol/L; **To be determined**
  - b. untreated hypogonadism can increase the risk of:
    - i. heart disease; **To be determined**
    - ii. Alzheimer's disease; **To be determined**
    - iii. premature death; **To be determined**
  - c. the treatment provided was TRT; **To be determined**
  - d. Patient M will not take 'any type of anabolic steroid'. **To be determined**
55. You knew that the information in the Consent Forms was untrue as:
- a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **To be determined**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **To be determined**
    - ii. Alzheimer's disease; **To be determined**
    - iii. premature death; **To be determined**
  - c. the treatment to be provided would increase testosterone above normal limits and was not TRT; **To be determined**

- d. you prescribed, or arranged to be prescribed, anabolic steroids to Patient M. **To be determined**
- 56. Your conduct as set out at paragraph 54 was dishonest by reason of paragraph 55. **To be determined**
- 57. You did not obtain informed consent from Patient M for treatment you provided in that:
  - a. you failed to counter-sign the Consent Forms; **To be determined**
  - b. the Consent Forms contained statements which were untrue. **To be determined**

Patient N

- 58. Between 25 April 2018 and 19 November 2018, you failed to provide good clinical care to Patient N in that you:
  - a. did not hold a consultation with Patient N; **To be determined**
  - b. did not elicit an adequate medical history in that you did not elicit details of:
    - i. sexual symptoms; **To be determined**
    - ii. non-sexual symptoms; **To be determined**
    - iii. answers to general health questions concerning the presenting complaint; **To be determined**
  - c. relied upon the responses of Patient N to inadequate email enquiries as the basis for clinical decision-making; **To be determined**
  - d. did not perform any physical or mental health examination of Patient N; **To be determined**
  - e. inappropriately diagnosed Patient N with hypogonadism in that:
    - i. the diagnosis was contrary to laboratory results; **To be determined**
    - ii. you failed to consider any underlying causes for the laboratory results; **To be determined**

- iii. you failed to consider any alternative diagnosis;  
**To be determined**
- f. prescribed Patient N with testosterone:
  - i. which was:
    - 1. not clinically indicated; **To be determined**
    - 2. unsafe; **To be determined**
  - ii. without explaining the risks and benefits to Patient N;  
**To be determined**
- g. increased the original dosage of prescribed testosterone from 11.9 mg/day to 25mg/day:
  - i. without any clinical basis for doing so;  
**To be determined**
  - ii. when Patient N suggested seeking the services of another provider if the dosage wasn't increased;  
**To be determined**
  - iii. knowing that in doing so you were supporting Patient N's abuse of testosterone medication;  
**To be determined**
- h. did not adequately communicate with Patient N in that you did not:
  - i. maintain regular contact during the course of Patient N's treatment; **To be determined**
  - ii. respond to concerns raised by Patient N in July 2018 relating to symptoms characteristic of over treatment of testosterone; **To be determined**
  - iii. delegated communications with Patient N to non-medically trained staff when it was not appropriate to do so; **To be determined**
- i. did not provide any oversight on clinical matters to non-medical members of staff advising Patient N during his treatment; **To be determined**
- j. inappropriately agreed not to inform Patient N's general practitioner of your care and treatment; **To be determined**

- k. did not review:
  - i. Patient N's further laboratory results received once treatment commenced; **To be determined**
  - ii. Patient N's treatment plan following concerns raised regarding possible over treatment of testosterone as set out at paragraph 58h.ii above; **To be determined**
- l. did not maintain adequate medical records throughout the period of treatment of Patient N. **To be determined**

#### Patient O

59. Between 15 May 2018 and 29 December 2018, you failed to provide good clinical care to Patient O in that you:
- a. consulted with Patient O on 15 May 2018 and you did not elicit an adequate medical history in that you:
    - i. inappropriately relied upon details obtained by a non-medically trained member of staff; **To be determined**
    - ii. failed to reconcile contradictory statements given by Patient O previously regarding his medical history; **To be determined**
    - iii. failed to ask any general health questions concerning the presenting complaint; **To be determined**
    - iv. failed to elicit details of Patient O's psychological background; **To be determined**
  - b. diagnosed Patient O with hypogonadism when laboratory evidence did not support a diagnosis of hypogonadism; **To be determined**
  - c. did not perform any physical or mental health examination of Patient O; **To be determined**
  - d. did not conduct / arrange a full blood count before prescribing medication to Patient O; **To be determined**
  - e. prescribed testosterone, anastrozole, mesterolone and tamoxifen which was: **To be determined**
    - i. not clinically indicated; **To be determined**

- ii. unsafe; **To be determined**
- iii. not recognised as therapeutic practice in medicine;  
**To be determined**
- f. did not make the necessary changes to Patient O's medication when he started to exhibit symptoms associated with over-prescribing of testosterone in that you:
  - i. failed to reduce Patient O's testosterone medication far enough; **To be determined**
  - ii. escalated the dosage of oestrogen blockers;  
**To be determined**
- g. did not adequately communicate with Patient O in that you failed to maintain regular correspondence; **To be determined**
- h. did not maintain adequate medical records throughout the period of treatment of Patient O; **To be determined**
- i. did not obtain informed consent from Patient O in that:
  - i. the information provided to Patient O before treatment was:
    - 1. inaccurate; **To be determined**
    - 2. misleading; **To be determined**
  - ii. the Consent Forms for:
    - 1. the treatment plan was not counter-signed by Patient O; **To be determined**
    - 2. electronic communication was not signed by either yourself or Patient O. **To be determined**

#### Patient P

60. In September 2018, you failed to provide good clinical care to Patient P in that you:
- a. did not hold a consultation with Patient P; **To be determined**
  - b. did not elicit an adequate medical history from Patient P, in that you did not elicit details of:
    - i. sexual symptoms; **To be determined**

- ii. non-sexual symptoms; **To be determined**
- iii. answers to general systems-orientated questions;  
**To be determined**
- c. did not perform any physical or mental health examination of Patient P; **To be determined**
- d. prescribed testosterone, hCG and anastrozole:
  - i. which was inappropriate in that it was:
    - 1. not clinically indicated; **To be determined**
    - 2. unsafe; **To be determined**
    - 3. not recognised as therapeutic practice in medicine; **To be determined**
  - ii. without explaining the risks and benefits to Patient P;  
**To be determined**
- e. did not conduct / arrange all necessary tests before prescribing medication to Patient P; **To be determined**
- f. did not review Patient P's treatment plan; **To be determined**
- g. did not communicate at all with Patient P during the course of his treatment; **To be determined**
- h. did not provide adequate follow up care; **To be determined**
- i. did not maintain adequate medical records throughout the period of treatment of Patient P. **To be determined**

#### Patient Q

- 61. In November 2018, you failed to provide good clinical care to Patient Q in that you:
  - a. did not hold a consultation with Patient Q; **To be determined**
  - b. did not elicit an adequate medical history from Patient Q, in that you did not elicit details of:
    - i. sexual symptoms; **To be determined**
    - ii. non-sexual symptoms; **To be determined**

- iii. answers to general health questions concerning the presenting complaint; **To be determined**
  - c. did not perform any physical or mental health examination of Patient Q; **To be determined**
  - d. prescribed testosterone and anastrozole:
    - i. which was inappropriate in that it was:
      - 1. not clinically indicated; **To be determined**
      - 2. unsafe; **To be determined**
      - 3. not recognised as therapeutic practice in medicine; **To be determined**
    - ii. without explaining the risks and benefits to Patient Q; **To be determined**
  - e. did not conduct / arrange all necessary tests before prescribing medication to Patient Q; **To be determined**
  - f. did not adequately communicate with Patient Q in that you delegated communications to non-medically trained members of staff when it was inappropriate to do so; **To be determined**
  - g. did not review Patient Q's treatment plan; **To be determined**
  - h. did not provide adequate follow up care; **To be determined**
  - i. did not maintain adequate medical records throughout the period of treatment of Patient Q. **To be determined**

#### Patient R

- 62. Between November 2018 and March 2019, you failed to provide good clinical care to Patient R in that you:
  - a. did not hold a face-to-face consultation with Patient R; **To be determined**
  - b. did not elicit an adequate medical history from Patient R, in that you did not elicit details of:
    - i. sexual symptoms; **To be determined**
    - ii. non-sexual symptoms; **To be determined**

- iii. answers to general health questions concerning the presenting complaint; **To be determined**
    - c. did not perform any physical / mental state examination of Patient R; **To be determined**
    - d. prescribed testosterone, hCG and anastrozole:
      - i. which was inappropriate in that it was:
        - 1. not clinically indicated; **To be determined**
        - 2. unsafe; **To be determined**
        - 3. not recognised as therapeutic practice in medicine; **To be determined**
      - ii. without explaining the risks and benefits to Patient R; **To be determined**
    - e. did not conduct / arrange all necessary tests before prescribing medication to Patient R; **To be determined**
    - f. did not review Patient R's treatment plan; **To be determined**
    - g. did not provide adequate follow up care; **To be determined**
    - h. did not maintain adequate medical records throughout the period of treatment of Patient R. **To be determined**
63. The treatment to the patients as set out at paragraphs 1 - 62 above was:
- a. provided:
    - i. outside the limits of your expertise as a consultant gastroenterologist; **To be determined**
    - ii. whilst failing to adhere to national and international guidelines; **To be determined**
    - iii. without the necessary qualifications, training and experience; **To be determined**
    - iv. whilst exposing them to risks of:
      - 1. androgen toxicity, including: **To be determined**

- 2. testosterone-induced erythrocytosis;  
**To be determined**
- v. knowing or believing that it was to be used by the patients for reasons not based on any clinical need;  
**To be determined**
- b. financially motivated. **To be determined**

## Transgender Patients

### Patient S

64. Between February 2017 and November 2018, you failed to provide good clinical care to Patient S in that you:
- a. did not establish an adequate Multi-Disciplinary Team ('MDT'); **To be determined**
  - b. did not conduct any:
    - i. physical assessment; **To be determined**
    - ii. face-to-face or video consultation with Patient S;  
**To be determined**
  - c. relied upon an inadequate mental health assessment in that you:
    - i. relied entirely upon the opinions of counsellors:
      - 1. without adequate qualifications;  
**To be determined**
      - 2. without registration with a recognised regulatory body; **To be determined**
      - 3. who conducted a telephone interview of unknown quality or duration; **To be determined**
      - 4. who produced a report which you should have recognised was not sufficiently detailed;  
**To be determined**
    - ii. did not liaise with Patient S's mental health workers;  
**To be determined**

- iii. did not engage with Patient S's mental health workers when they actively sought to communicate with you; **To be determined**
    - iv. did not ensure the assessment process was adapted to account for Patient S's needs; **To be determined**
  - d. reached a diagnosis of gender dysphoria based upon findings resulting from your inadequate assessment as set out at paragraphs 64b – c above; **To be determined**
  - e. prescribed oestrogen and anti-androgens to Patient S without:
    - i. being able to ensure it was clinically-indicated; **To be determined**
    - ii. adequately monitoring, throughout the course of treatment, Patient S's:
      - 1. physical response to treatment; **To be determined**
      - 2. psychosocial response to treatment; **To be determined**
    - iii. discussing alternative treatments with Patient S; **To be determined**
  - f. continued to prescribe oestrogen to Patient S despite evidence that:
    - i. the dose was excessive; **To be determined**
    - ii. Patient S was starting to experience known risks; **To be determined**
  - g. did not directly notify Patient S's GP, Dr ML, regarding any treatment you prescribed to Patient S; **To be determined**
  - h. did not make any changes to your clinical management of Patient S when they:
    - i. failed to obtain blood results upon request; **To be determined**
    - ii. failed to check their blood pressure upon request; **To be determined**

- iii. returned abnormal results in relation to paragraph 64h.i – ii; **To be determined**
    - i. did not seek to conduct any follow up consultation between Patient S and:
      - i. yourself; **To be determined**
      - ii. an appropriately qualified person; **To be determined**
    - j. did not adequately communicate with Patient S in that you:
      - i. did not contact Patient S with adequate frequency throughout their period of treatment; **To be determined**
      - ii. inappropriately delegated communications to:
        - 1. administrative staff; **To be determined**
        - 2. counsellors; **To be determined**
      - iii. failed to adapt communications appropriately to take into account the fact that Patient S is on the autistic spectrum; **To be determined**
    - k. did not obtain informed consent in that you:
      - i. did not adequately assess Patient S's capacity to consent; **To be determined**
      - ii. failed to counter-sign the consent form; **To be determined**
      - iii. commenced treatment without Patient S having signed the consent form. **To be determined**
65. You provided treatment to Patient S as outlined at paragraph 64 above:
- a. outside the limits of your expertise as a consultant gastroenterologist; **To be determined**
  - b. without the necessary qualifications and training and experience in:
    - i. transgender medicine; **To be determined**

- ii. assessing capacity and autonomy in an adolescent with mental health issues; **To be determined**
- c. whilst failing to adhere to a recognised training pathway in transgender medicine. **To be determined**

Patient T

66. Between May 2017 and January 2018, you failed to provide good clinical care in that you:
- a. did not establish an adequate MDT; **To be determined**
  - b. did not advise Patient T's GP ('Dr DP') that you had taken over the care of Patient T from Dr HW; **To be determined**
  - c. sought a shared-care agreement with Dr DP which was inappropriate in that you were unqualified to:
    - i. autonomously prescribe to minors; **To be determined**
    - ii. sign-off on shared-care agreement involving minors; **To be determined**
  - d. continued to prescribe injections of gonadotrophin releasing-hormone ('GnRH') off-licence to Patient T without:
    - i. up to date blood tests; **To be determined**
    - ii. any periodic appraisals of Patient T's condition through face-to-face or video consultations; **To be determined**
  - e. did not arrange an assessment of Patient T by an appropriately qualified expert in transgender minors; **To be determined**
  - f. did not recognise that the initial psychological assessment was insufficiently detailed; **To be determined**
  - g. review Patient T's consent to treatment when it was apparent that:
    - i. not all risks had been discussed with Patient T; **To be determined**
    - ii. Patient T's capacity to consent had not been adequately considered; **To be determined**

- iii. Patient T's consent form had been received remotely, not affording them the opportunity to ask questions; **To be determined**
  - h. inappropriately relied solely on Patient T's mother to provide updates relating to Patient T's condition. **To be determined**
- 67. You provided treatment to Patient T as outlined at paragraph 66 above:
  - a. on behalf of Dr HW whilst she was subject to an interim order of suspension; **To be determined**
  - b. outside the limits of your expertise as a consultant gastroenterologist; **To be determined**
  - c. without the necessary qualifications and training in:
    - i. paediatrics; **To be determined**
    - ii. general practice; **To be determined**
    - iii. clinical management of a minor; **To be determined**
  - d. whilst failing to adhere to a recognised training pathway in transgender medicine. **To be determined**

Patient U

- 68. Between May 2017 and July 2018, you failed to provide good clinical care to Patient U in that you:
  - a. did not establish an adequate MDT; **To be determined**
  - b. diagnosed Patient U with gender dysphoria on 15 July 2017:
    - i. without any face-to-face or video consultations with Patient U; **To be determined**
    - ii. without receiving any information from Patient U's GP to corroborate information received from Patient U via the online questionnaire completed on 23 May 2017; **To be determined**
    - iii. based upon psychological assessments from counsellors:
      - 1. who were unregulated; **To be determined**

2. who had never met Patient U;  
**To be determined**
  3. which you should have recognised were insufficiently detailed; **To be determined**
- c. prescribed private prescriptions of Testosterone Gel ('TestoGel') between 28 June 2017 and 30 May 2018, each of eight weeks' supply, which was not clinically indicated in that you:
- i. had not received relevant information from Patient U's GP; **To be determined**
  - ii. did not communicate with Patient U's mental health workers beforehand; **To be determined**
- d. did not ensure informed consent had been obtained from Patient U in that you:
- i. only obtained consent remotely and did not allow Patient U the opportunity to engage with you personally to discuss risks and benefits of treatment; **To be determined**
  - ii. inadequately assessed Patient U's understanding of the risks and benefits of treatment in that you only asked them to provide a written summary; **To be determined**
  - iii. did not inform yourself of Patient U's involvement with mental health workers, specifically:
    1. the mental health workers' concerns regarding gender affirming treatment; **To be determined**
    2. Patient U's capacity to provide informed consent. **To be determined**
69. On 21 September 2017, when Patient U was temporarily uncontactable, you failed to:
- a. suspend Patient U's gender-affirming treatment, including administration of TestoGel; **To be determined**
  - b. advise the following that the gender-affirming treatment, including administration of TestoGel, should be suspended:
    - i. Patient U; **To be determined**

- ii. Patient U's GP. **To be determined**
70. You continued to prescribe eight weeks' supply of TestoGel to Patient U even though you:
- a. learned that CMHT had previously disagreed with TestoGel treatment; **To be determined**
  - b. had reasons to believe that Patient U was regularly over-dosing on the prescribed TestoGel. **To be determined**
71. You provided treatment to Patient U as outlined at paragraph 68 - 70 above:
- a. outside the limits of your expertise as a consultant gastroenterologist; **To be determined**
  - b. without the necessary qualifications and training in general practice; **To be determined**
  - c. whilst failing to adhere to a recognised training pathway in transgender medicine. **To be determined**

Patient V

72. Between May 2018 and October 2018, you failed to provide good clinical care to Patient V in that you:
- a. did not establish an adequate MDT; **To be determined**
  - b. diagnosed Patient V as suffering from gender dysphoria in July 2018:
    - i. based upon a questionnaire which was inadequate for assessment of a minor; **To be determined**
    - ii. without performing an adequate:
      - 1. mental state examination; **To be determined**
      - 2. physical examination; **To be determined**
  - c. started to prescribe GnRH-antagonist ('GnRHa') injections off-licence to Patient V on 18 July 2018 without;
    - i. blood test results to confirm biochemical puberty; **To be determined**

- ii. arranging a baseline bone density scan;  
**To be determined**
- iii. considering alternative treatments; **To be determined**
- iv. being able to adequately assess the balance between the risks and benefits of prescribing GnRHa to Patient V; **To be determined**
- v. adequately advising of the risks to Patient V's parents;  
**To be determined**
- vi. informing Dr K, Patient V's GP; **To be determined**
- d. continued to prescribe GnRHa to Patient V without first conducting a period of assessment over several months;  
**To be determined**
- e. did not obtain informed consent from Patient V in that you:
  - i. did not adequately assess Patient V as being Gillick competent; **To be determined**
  - ii. in the alternative to Paragraph 72e.i, did not record how you reached the conclusion that Patient V was Gillick competent; **To be determined**
  - iii. failed to discuss the full risks and benefits of treatment with Patient V directly; **To be determined**
- f. did not obtain informed consent from Patient V's parents on 29 June 2018 in that:
  - i. you obtained consent for testosterone treatment seven years before Patient V could receive it;  
**To be determined**
  - ii. you did not counter-sign the leaflet provided to Patient V's parents detailing the intended treatment ('the Leaflet'); **To be determined**
  - iii. the Leaflet incorrectly advised that hormone blockers are fully reversible; **To be determined**
- g. provided information ('the Information') to Patient V's parents which:
  - i. failed to declare:

1. your lack of qualifications to manage the care of minors; **To be determined**
  2. that Dr HW was no longer a credible MDT member as she was subject to an interim order of suspension; **To be determined**
- ii. detailed an inadequate MDT make-up;  
**To be determined**
- iii. stated that:
1. GnRHa was required to entirely prevent the onset of puberty in suspected transgender minors, which is contrary to expert guidance;  
**To be determined**
  2. there was a 50% risk of attempted suicide in young transgender clients, which was not based upon UK statistics; **To be determined**
  3. Dr TS was a Consultant Clinical Psychologist, when she was a qualified counsellor;  
**To be determined**
  4. Dr VP was a Consultant Clinical Psychologist, when she was a registered Counselling Psychologist; **To be determined**
- iv. made incorrect statements about NHS transgender services, including that:
1. the 'minimum expected wait for treatment is likely to be five and a half years';  
**To be determined**
  2. as a consequence of delay, transgender minors would necessarily require more extensive surgery in the future; **To be determined**
- v. incorrectly advised that:
1. hormone blockers were 'fully reversible';  
**To be determined**
  2. testosterone could be prescribed to patients under 16 in exceptional circumstances.  
**To be determined**

73. The distribution of the Information was:
- a. done in order to persuade Patient V's parents to use Gender GP for the care and treatment of Patient V; **To be determined**
  - b. financially motivated. **To be determined**
74. You provided treatment to Patient V as outlined at paragraph 72 above:
- a. outside the limits of your expertise as a consultant gastroenterologist; **To be determined**
  - b. without the necessary qualifications and training in:
    - i. paediatrics; **To be determined**
    - ii. general practice; **To be determined**
    - iii. clinical management of a minor; **To be determined**
  - c. whilst failing to adhere to a recognised training pathway in transgender medicine. **To be determined**

Patient W

75. Between June 2018 and September 2018, you failed to provide good medical care to Patient W in that you:
- a. diagnosed Patient W with gender dysphoria and did not:
    - i. establish an adequate MDT; **To be determined**
    - ii. carry out any face-to-face consultations with Patient W; **To be determined**
    - iii. carry out an adequate:
      1. physical examination; **To be determined**
      2. mental state examination; **To be determined**
    - iv. corroborate any of the information provided to you by Patient W with:
      1. Patient W's GP, Dr GY; **To be determined**
      2. Patient W's mental health workers; **To be determined**

3. the nurse at Patient W's school;  
**To be determined**
- v. seek further information regarding Patient W's mental health from:
  1. Dr GY; **To be determined**
  2. Patient W's mental health workers;  
**To be determined**
  3. the nurse at Patient W's school;  
**To be determined**
- b. prescribed testosterone to Patient W:
  - i. which was not clinically-indicated; **To be determined**
  - ii. without first establishing whether the risks of prescribing testosterone were lower than the risks to Patient W's mental and physical health if not prescribed; **To be determined**
  - iii. before entering into a shared care agreement with Dr GY; **To be determined**
  - iv. without informing Dr GY that you had commenced testosterone treatment; **To be determined**
- c. did not record any details as to the prescribing of testosterone to Patient W, including:
  - i. dosage; **To be determined**
  - ii. date of prescription; **To be determined**
- d. did not obtain informed consent from Patient W in that you:
  - i. failed to countersign the consent form;  
**To be determined**
  - ii. provided no details as to the verbal consenting process, including whether appropriate communication in dealing with a patient with autism was employed; **To be determined**
- e. did not provide adequate follow up care. **To be determined**

76. You provided treatment to Patient W as outlined at paragraph 75 above:
- a. outside the limits of your expertise as a consultant gastroenterologist; **To be determined**
  - b. without the necessary qualifications and training and experience in transgender medicine; **To be determined**
  - c. whilst failing to adhere to a recognised training pathway in transgender medicine. **To be determined**

Patient X

77. Between August 2018 and June 2019, you failed to provide good clinical care to Patient X in that you:
- a. did not establish an adequate MDT; **To be determined**
  - b. diagnosed Patient X with gender dysphoria:
    - i. without any face-to-face or video consultations with Patient X; **To be determined**
    - ii. based upon physical and psychological assessments:
      1. from unqualified staff; **To be determined**
      2. which you should have recognised were insufficiently detailed; **To be determined**
    - iii. without obtaining an adequate medical history; **To be determined**
  - c. prescribed a 12-week supply of oestradiol patches (100 mcg, twice weekly), micronized progesterone (100 mg, daily) and spironolactone (100 mg daily) to Patient X in March 2019 without:
    - i. any personal contact with Patient X during the course of treatment; **To be determined**
    - ii. obtaining a basic medical history; **To be determined**
    - iii. carrying out a:
      1. physical state examination; **To be determined**
      2. mental state examination; **To be determined**

- iv. an adequate discussion with Patient X about the risks and benefits of treatment; **To be determined**
- v. considering Patient X's baseline investigations beforehand; **To be determined**
- vi. recording the basis for the prescription; **To be determined**
- vii. a plan for holistic review of Patient X's progress apart from blood tests; **To be determined**
- d. prescribed micronized progesterone:
  - i. contrary to guidance; **To be determined**
  - ii. without evidence of any benefit to Patient X; **To be determined**
  - iii. which increased the risks to Patient X of:
    - 1. impaired breast development; **To be determined**
    - 2. venous thrombo-embolism; **To be determined**
    - 3. breast cancer; **To be determined**
- e. did not keep any records of your care and treatment of Patient X; **To be determined**
- f. did not obtain informed consent from Patient X in that you:
  - i. failed to directly contribute to the consenting process with Patient X; **To be determined**
  - ii. failed to counter-sign the consent documentation; **To be determined**
  - iii. obtained consent remotely which did not allow Patient X the opportunity to engage with you personally to discuss risks and benefits of treatment; **To be determined**
  - iv. failed to adequately assess Patient X's capacity in light of their mental health concerns. **To be determined**

78. Your conduct as described at paragraphs 77c – e above was in breach of the interim order of conditions imposed upon your registration during the period of time you treated Patient X. **To be determined**
79. You provided treatment to Patient X as outlined at paragraph 77 above:
- a. outside the limits of your expertise as a consultant gastroenterologist; **To be determined**
  - b. without the necessary qualifications and training and experience in transgender medicine; **To be determined**
  - c. whilst failing to adhere to a recognised training pathway in transgender medicine. **To be determined**

Patient Y

80. Between 15 October 2018 and 22 March 2019, you failed to provide good clinical care to Patient Y in that you:
- a. did not establish an adequate MDT; **To be determined**
  - b. diagnosed Patient Y as suffering from gender dysphoria based solely upon:
    - i. Patient Y's answers to Gender GP questionnaires without further investigation; **To be determined**
    - ii. the content of Patient Y's emails in exchanges with Gender GP staff who lacked the necessary qualifications in mental or physical healthcare; **To be determined**
    - iii. a report by a counsellor who:
      1. lacked adequate qualifications to reach a clinical diagnosis of gender dysphoria; **To be determined**
      2. only engaged with Patient Y in a single 20-minute video consultation; **To be determined**
    - iv. a 30-minute consultation with Patient Y by a registered nurse who failed to keep a formal record of that consultation; **To be determined**

- c. did not conduct any examination yourself, including that you did not:
  - i. elicit a face-to-face medical history; **To be determined**
  - ii. conduct a mental state examination; **To be determined**
  - iii. obtain basic clinical observations; **To be determined**
- d. allowed Patient Y to be prescribed cross-hormone testosterone treatment:
  - i. by individuals who were not recognised specialists in transgender medicine; **To be determined**
  - ii. without any personal consultation with Patient Y in order to:
    - 1. elicit a basic medical history; **To be determined**
    - 2. conduct a physical state examination; **To be determined**
    - 3. conduct a mental state examination; **To be determined**
    - 4. discuss risks and benefits of proposed treatment; **To be determined**
- e. did not advise Patient Y or any of Patient Y's GPs during the period of treatment through Gender GP that you were not directly prescribing to Patient Y; **To be determined**
- f. did not plan to review Patient Y throughout the period of treatment in order to periodically assess their:
  - i. physical wellbeing; **To be determined**
  - ii. mental wellbeing; **To be determined**
  - iii. feelings towards anticipated changes resulting from hormone therapy; **To be determined**
- g. did not adjust the testosterone prescriptions for Patient Y when blood results showed that Patient Y had:
  - i. nearly twice the upper limit of testosterone in the normal male reference range; **To be determined**

- ii. developed abnormalities in their red blood cell morphology; **To be determined**
  - h. did not establish a treatment plan for Patient Y, including:
    - i. arrangements for face-to-face reviews every three to four months; **To be determined**
    - ii. target ranges to be achieved for blood test results; **To be determined**
  - i. did not liaise with Patient Y's mental health workers; **To be determined**
  - j. did not personally participate in the process of obtaining consent from Patient Y in that you failed to:
    - i. contemporaneously counter-sign Patient Y's consent to treatment form; **To be determined**
    - ii. give Patient Y the opportunity to discuss risks and benefits of the proposed treatment with you; **To be determined**
  - k. did not maintain you own medical records for Patent Y. **To be determined**
81. You provided treatment to Patient Y as outlined at paragraph 80 above:
- a. outside the limits of your expertise as a consultant gastroenterologist; **To be determined**
  - b. without the necessary qualifications and training and experience in transgender medicine; **To be determined**
  - c. whilst failing to adhere to a recognised training pathway in transgender medicine. **To be determined**
82. Your actions as described at one or more of paragraphs 64 - 81 were outwith UK guidance in that they were contrary to the NHS Standard Contract for Gender Identity Development Service for Children and Adolescents issued in 2016. **To be determined**

### **Gender GP**

83. Until 2019, alongside Dr HW, you operated and controlled the company known as Gender GP, through which you provided care and treatment as stated at paragraphs 64 – 82 above. **To be determined**
84. In 2019, on the governance page of the Gender GP website it stated that ‘all medical advice and prescriptions are provided by doctors working outside of the UK’. **To be determined**
85. The operating method of Gender GP as described at paragraph 84 above was motivated by efforts to avoid the regulatory framework of the United Kingdom, including regulation by the:
- a. CQC; **To be determined**
  - b. HIW. **To be determined**
86. In November 2018:
- a. the only General Practitioner at Gender GP, Dr HW, was subject to an interim order of suspension (‘the IOT Order’); **To be determined**
  - b. there were no other GPs practising as part of Gender GP. **To be determined**
87. You knew that following the IOT Order:
- a. Dr HW was unable to participate in the work of Gender GP in her capacity as General Practitioner; **To be determined**
  - b. there were no other GPs practising as part of Gender GP. **To be determined**
88. Following the IOT Order you retained the name of your company as Gender GP. **To be determined**
89. Your conduct as outlined at paragraph 88 above was dishonest by reason paragraphs 86 and 87. **To be determined**

### **Documentary Evidence**

38. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included but was not limited to:
- Witness statement of Patient F, dated 12 April 2019, including blood test results and correspondence with BMH, 23 October – 14 December 2017;
  - Witness statement of Patient L, dated 26 April 2019, and supplementary witness statement, dated 29 August 2021, including blood test results and correspondence with BMH and Dr Webberley, various;

- Witness statement of Patient N, dated 1 May 2019, correspondence with Dr Webberley, various;
- Witness statement of Patient P, dated 21 March 2019, and supplementary witness statement, dated 2 September 2021, including blood test results and correspondence from Dr Webberley, dated 18 September 2018;
- Witness statement of Patient Q, dated 17 April 2019, and supplementary witness statement, dated 18 August 2019, including a letter from Dr Webberley, dated 12 November 2018;
- Witness statement of Patient R, dated 8 July 2019, and supplementary witness statement, dated 27 August 2021, including correspondence from BMH, 29-30 November 2018 and 19-12 December 2018;
- Witness statement of Dr Rhiannon Tasker, Specialty Doctor for Child and Adolescent Mental Health Services ('CAMHS') at Cwm Taf Health Board, NHS Wales (in relation to Patient S), dated 18 October 2021;
- Witness statement of Dr Dhrushil Patel, General Practitioner at Sunny Meed Surgery (in relation to Patient T), dated 14 September 2018, including various correspondence from Dr HW and Dr Webberley, and a GMC complaint, dated 7 November 2017;
- Witness statement of Professor Gary Butler, Consultant in Paediatric and Adolescent Endocrinology at University College London Hospitals (in relation to Patient T), dated 22 November 2018, including; correspondence with Dr Patel, 19 September 2017 and 23 November 2017; NHS Standards contract for GIDS (2016), and an article titled 'Assessment and support of Children and Adolescents with Gender Dysphoria';
- Witness statement of Serena James, Community Mental Health Nurse at Ty Einon Centre, Swansea (in relation to Patient U), dated 10 January 2019, and supplementary witness statement dated, 21 September 2021, including her GMC compliant referral, dated 11 September 2017;
- Witness statement of Dr Natalie Wookey, GP at Mumbles Medical Practice (in relation to Patient U), dated 16 October 2018, including correspondence with Dr Webberley, dated 28 June 2017 and 26 September 2017;
- Witness statement of Patient U's mother (in relation to Patient U), dated 7 May 2019, including correspondence with Dr Webberley and Gender GP, various;
- Witness statement of Dr Dorothy King, retired GP, previously of Fountains Medical Practice, Chester (in relation to Patient V), dated 9 September 2021;
- Witness statement of Dr Ian Minshall, GP at Fountains Medical Practice, Chester and Northgate Village Surgery (in relation to Patient V), dated 5 October 2021;
- Witness statement of Patient W's father (in relation to Patient W), dated 7 November 2019, including the consent form for testosterone from Dr Webberley, dated 7 September 2019;
- Witness statement of Dr Ge Yu, GP at The Orchard Surgery (in relation to Patient W), dated 21 September 2019;
- Witness statement of Dr Lucy Duckworth, GP at Oldbury Health Centre (in relation to Patient X), dated 25 June 2019, Including correspondence from Dr Webberley, various;

- Witness statement of Dr Jamie Lewis, GP at Ashbourne Medical Practice (in relation to Patient Y), dated 30 May 2019, including GMC complaint referral, dated 1 March, 2019.

### Expert Witness Evidence

39. The Tribunal received evidence from two expert witnesses. In relation to the androgen and transgender patients, Dr Richard Quinton, Consultant Endocrinologist, provided seven expert reports dated: 10 November 2019, 20 June 2019, 15 April 2019, 15 May 2019, 31 August 2019, 30 April 2020 and 05 September 2019. Dr Quinton also provided oral evidence to the Tribunal.

40. In relation to the transgender patients, Dr Alanna Kierans, Specialist Clinical Psychologist, provided an expert report, dated 6 October 2021. Dr Kierans also provided oral evidence to the Tribunal.

### Medical Records

- Medical records from BMH and Men’s Health Clinic patient contact notes, for Patients A, B, C, D, E, G, H, J, K, L, M, N, and O;
- Men’s Health Clinic patient contact notes, for Patients F, Q and R;
- Medical records from BMH for Patient I;
- CAMHS and Gender GP records for Patient S;
- NHS GP records and Gender GP records for Patients T, U, V, X and Y;
- NHS records only for Patient W.

### GMC Guidance

- Consent: Patients and doctors making decisions together, 2 June 2008;
- Good Medical Practice, 22 April 2013;
- Good practice in prescribing and managing medicines and devices, December 2014;
- Written evidence submitted by the General Medical Council to the Transgender Equality Enquiry, 9 November 2015;
- Advice for doctors treating trans patients, March 2016;
- Treatment pathways: referral to a Gender Identity Clinic (‘GIC’), 2017;
- GMC Ethical Hub: Trans Healthcare, 2019.

### Other guidance/ protocols

- Standards of Care for the Health of Transsexual, Transgender, and Gender - Nonconforming People - The World Professional Association for Transgender Health (V7 - 2012);
- Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society\*Clinical Practice Guideline, J Clin Endocrinol Metab, November 2017;
- NHS Standard Contract for gender identity development service for children and adolescents, period 1 April 2016 to 1 April 2020;

- Royal College of General Practitioners - Guidelines for the Care of Trans\* Patients in Primary Care (2015);
- Guidance for GPs, other clinicians and health professionals on the care of gender variant people. (NHS/Department of Health), dated 10 March 2008;
- Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline, Journal of Clinical Endocrinology and Metabolism, dated 1 September 2009;
- Statement on the Management of Gender Identity Disorder (GID) in Children & Adolescents, The British Society for Paediatric Endocrinology and Diabetes, dated December 2009;
- Good practice guidelines for the assessment and treatment of adults with gender dysphoria, Royal College of Psychiatrists, dated October 2013;
- Interim Gender Dysphoria Protocol and Service Guideline 2013/14, NHS England, dated 28 October 2013;
- Primary Care responsibilities in relation to the prescribing and monitoring of hormone therapy for patients undergoing or having undergone Gender dysphoria treatments, dated 26 March 2014;
- Approach to the Patient: Transgender Youth: Endocrine Considerations, NHS England;
- Specialised Services Circular, dated 1 December 2014;
- Clinical Commissioning Policy: Prescribing of Cross-sex hormones as part of the Gender Identity Development Service for Children and Adolescents, NHS England, dated 22 August 2016;
- Clinical Management of Gender Identity Disorder in Adolescents: A Protocol on Psychological and Paediatric Endocrinology Aspects, European Journal of Endocrinology, 2006;
- 'Society for Endocrinology Guidelines for Testosterone Replacement Therapy in Male Hypogonadism' (Quinton et al), 2021.

#### Academic Papers

- 'Serving Transgender Youth – Challenges, Dilemmas and Clinical Examples' (Tishelman, Kaufman, Edwards-Leeper, Mandel, Shumer & Spack), 2015;
- 'The Role of Assent in Treatment of Transgender Adolescents' (Schumer, Tishelman), 2015;
- 'Approach to the Patient: Transgender Youth: Endocrine considerations' (Rosenthal), 2014;
- 'Gender Dysphoria and Adolescents' (Leibowitz and Dr Vries), 2016;
- 'Child and Adolescent Gender Center: a Multidisciplinary Collaboration to Improve the Lives of Gender Non-conforming Children and Teens' (Sherer, Rosenthal, Ehreshaft, Baum), 2012;

#### On behalf of Dr Webberley

41. Extracts from Dr Webberley's Interim Orders Tribunal (IOT) hearings and associated GMC investigation correspondence.

Documents submitted to the IOT held November 2018:

- Dr Webberley's CV;
- Dr Webberley's appraisal completion document, dated 12 November 2017;
- Testimonial evidence;
- GMC guidance on remote prescribing;
- Extract from report of Women and Equalities Committee report on transgender equality;
- Stonewall report on experience of the LGBTQI+ community in schools;
- BBC News article;
- GMC Guidance on trans healthcare.

Documents submitted to the IOT held February 2019:

- Guidance: 'Monitoring Feminising Hormone Therapy';
- Guidance: 'Monitoring Masculinising Hormone Therapy';
- CQC guidance: 'What is a Location?'

Additionally:

- Email correspondence between Dr Webberley and the GMC, various;
- Email from Dr Webberley to the GMC enclosing communications with the parents of Patient V, dated 17 July 2018;
- Gender GP correspondence received from Dr Webberley, dated 19 November 2018;
- Letter from Dr Webberley to HM Coroner regarding care and treatment provided to Patient W, dated 11 February 2018;
- Email from Dr Webberley to the GMC enclosing information on GMC expert Dr Quinton, dated 18-21 July 2019.

### **The Tribunal's Approach**

42. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr 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 events occurred. In reaching its determination, the Tribunal considered all the evidence and the submissions on behalf of the GMC.

43. The Tribunal were mindful that the burden of proof was upon the GMC throughout. Therefore, the Tribunal did not draw any inferences adverse to Dr Webberley by reason of the fact he was neither present nor represented, or because he had not given, or called evidence on his own behalf. The Tribunal did however have regard to the representations made by Dr Webberley in response to the allegations contained within the communications and documents provided by him during the course of the GMC investigation. The Tribunal gave them such weight as it considered appropriate.

## The Expert Evidence

44. In relation to all of the allegations concerning Patient A-Y, the GMC relied upon the expert evidence of Dr Quinton (the androgen and transgender patients) and Dr Kierans (the transgender patients alone, Patients S-Y).

45. The Tribunal heard evidence as to the qualifications, training and experience in their respective fields and which was set out in their reports.

46. The Tribunal accepted Dr Quinton's expertise and specialist knowledge in adult endocrinology and diabetes, and which included expertise in the field of adult male hypogonadism and patients with gender dysphoria (both minors and adults). In accepting Dr Quinton's expertise, and that he was qualified to give expert opinion evidence, the Tribunal had regard to Dr Webberley's challenge of Dr Quinton's expertise in respect of transgender medicine set out in an email to the GMC dated 21 July 2019. This challenge was on the basis that the Royal College of Physicians curriculum for endocrinology did not include a competency for the care of transgender patients and has no subspeciality in this field. Dr Webberley further stated that Dr Quinton's website profile did not make any reference to his involvement in the care of transgender patients, or experience in treating, or ability to treat or comment upon, transgender adolescents.

47. The Tribunal did not accept Dr Webberley's criticism of Dr Quinton's expertise in treating transgender patients. The Tribunal noted Dr Quinton's expertise in the field set out in his reports and confirmed in evidence, which included ten years affiliation with the Northern Region Gender Dysphoria Service providing (internal) medicine and endocrine advice and guidance to the Gender Multi-Disciplinary Team ('MDT'), the direct supervision of cross hormone therapies for patients referred to him by the MDT (typically those with complex medical issues). Dr Quinton's responsibilities in this capacity included seeing transgender patients on a weekly basis and regular communication with psychiatrists, psychologists, reproductive health physicians and specialist nurse members of the gender health MDT and attending clinical meetings of the MDT on monthly basis. The Tribunal acknowledged that Dr Quinton did not have direct experience as a lead clinician in the assessment of a patient's suitability or need for transition, neither did he have experience in the provision of transgender treatment in the private sector, or minors with gender related issues. However, he stated in his report that he had expert knowledge of the principles and practice of managing transgendered minors.

48. The Tribunal accepted Dr Kierans expertise and qualification as a specialist clinical psychologist with extensive experience in the assessment and treatment of transgender patients including children and adolescents. The Tribunal acknowledged that Dr Kierans experience derived from her work in an NHS GIDS (Gender Identity Service) and she did not have relevant experience in the treatment of patients in the private sector.

49. Throughout the Tribunal's deliberations, it bore in mind the fact that both Dr Quinton's and Dr Kierans' expert opinions were based upon their analysis of the

evidence as set out in the witness statements and medical records, and the inferences/assumptions that they had made therefrom.

50. The Tribunal was mindful throughout, that the issues of fact were for the Tribunal to determine based upon the primary evidence, and that whereas it could draw inferences where appropriate, it should not speculate or make assumptions which were not borne out by the evidence. As will become apparent, there were a number of instances when the Tribunal accepted the expert's opinion evidence but did not accept that the expert's factual premise was supported by the evidence. In these circumstances this invariably resulted in the particular allegation being found not proved.

### **The Medicine and Science Behind Male Hypogonadism**

51. Before analysing the evidence in relation to these patients and, given that in respect of all of these patients Dr Webberley purported to treat them for testosterone deficiency, a condition otherwise known as hypogonadism, it is necessary to give a summary of hypogonadism as a condition, its diagnosis and treatment. In this regard the Tribunal accepted the expert evidence of Dr Quinton.

#### **Biological actions of Testosterone**

52. The biological actions of testosterone in adult males are to sustain the following physical, psychological and behavioural functions:

- fertility and testicular volumes.
- libido (sex drive) and sexual function
- male-pattern facial, body and scalp hair (including male pattern baldness).
- bone density and strength, thereby protecting against osteoporosis and fracture.
- muscle bulk and strength, thereby protecting against weakness, frailty and fatigue.
- red blood cell production, thereby protecting against anaemia and fatigue.
- skin thickness and health, thereby protecting against age-related wrinkling.
- suppression of abnormal sweating and hot flushes.
- spatial orientation and awareness.
- motivation and optimism, thereby protecting against depression and social isolation.
- insulin-sensitivity, thereby potentially protecting against obesity and type 2 diabetes.

53. Only 2–3% of testosterone circulates unbound or free; around 60% is firmly bound to sex hormone binding globulin (SHBG) and around 40 more loosely bound to albumin. Online or laboratory based mass-action formulae allow the concentration of biologically active testosterone to be estimated by imputing levels, of testosterone, SHG and albumin.

54. In practice, these calculations are only worthwhile when the SHBG level lies towards one or other extreme of the normal range. For instance, men with

insulin-resistance arising from central obesity tend to run low SHBG levels, so that their total testosterone concentrations may appear low, but bio-available testosterone is usually normal.

### **Diagnosis and classification of male hypogonadism**

55. Men who wholly or partially lack endogenous testosterone secretion and sperm production are said to be hypogonadal, or to have hypogonadism. They are generally treated with testosterone replacement therapy in the form of regular intramuscular injections or the daily application of a testosterone gel. Properly administered testosterone replacement therapy is able to reproduce all the functions of endogenously-secreted testosterone apart from the maintenance of normal testicular volume and fertility.

56. Clinical suspicion that a man may be hypogonadal arises from recognition that one more of the functions listed in paragraph 50 are impaired, with sexual dysfunction being the most common, but by no means the only presentation. Biochemical characterisation is essential both to confirming the diagnosis and to defining the broad subtype of hypogonadism, which in turn determines the direction of further investigation.

57. Broadly, a low testosterone level with abnormally raised LH & FSH levels, unequivocally indicates a disorder of the testes, somewhat analogous to menopause in women, which Dr Quinton described as *'light bulb broken'*. However, whereas all women will eventually become menopausal – losing ovarian function completely – the vast majority of men maintain adequate testicular responsiveness to pituitary LH & FSH throughout their lives, with only around 1-2% of older men developing a primary loss of testicular function (rate of 0.2% per year).

58. A low testosterone level with low (or *"inappropriately normal"*) LH & FSH levels is consistent with several possible scenarios. First, there could be genuine hypogonadotropic hypogonadism (HH), indicating the possibility of a lesion in the pituitary gland (such as prolactinoma) causing secondary failure of testicular function through lack of LH & FSH stimulation, which Dr Quinton described as *'light switch off'*. Second, the blood tests could have been taken under non-standard conditions, post-prandial rather than fasted, or in the afternoon instead of early morning, reflecting biochemical artefact rather than true HH.

59. Finally, there could be physiological suppression of the pituitary-testicular axis from any non-gonadal illness (NGI), which unlike true HH is completely reversible with recovery from or successful treatment of that particular illness. NGI may reflect an ancient evolutionary adaptation to critical illness, wherein precious energy resources are diverted away from growth and reproduction and towards survival. It can be hard to definitively distinguish a primary defect of pituitary LH & FSH secretion (central or secondary hypogonadism) from non-gonadal illness (NGI), because the pattern of hormone levels is similar (low testosterone with low or *'inappropriately normal'* LH & FSH levels). A definitive answer may only emerge in retrospect upon removal or remission of the stressor, with spontaneous recovery of

the reproductive axis occurring after resolution of NGI, but (usually) lack of recovery in the context of hypopituitarism.

60. Other 'clues' pointing to NGI over true HH are pituitary function that is otherwise normal, the absence of anaemia or osteoporosis, and testicular volumes that are normal, but this is ultimately a clinical judgement based upon evaluation of multiple strands of patient-related information. Crucially, nearly all guidelines mandate checking fasted early morning testosterone levels on at least two occasions, preferably weeks apart, and to only consider a diagnosis of hypogonadism if it is found to be low on both occasions.

### **Testosterone products licensed in the UK**

61. Dr Quinton opined that these fall broadly into 3 categories: short-acting injectables (e.g. Testosterone cypionate [not available in the UK]; testosterone enanthate; Testosterone propionate; or the mixture of propionate, decanoate, isocaproate & phenylpropionate marketed as *Sustanon*<sup>®</sup>); long-acting depot injectable Testosterone undecanoate (*Nebido*<sup>®</sup>), and daily transdermal gel preparations.

62. Although the injectables are based on different esters of testosterone, they all undergo the same process of hydrolysis in the liver to release the same testosterone molecule and, apart from *Nebido*, have almost identical pharmacokinetics.

63. *Nebido* and gels became available in the UK around 15 years ago and are now more widely prescribed in the NHS than short-acting injectables, because they achieve far more stable serum testosterone levels, with much less peak-trough variation in serum levels. Moreover, *Nebido* only needs to be injected every 3–4 months, compared with every 1–3 weeks for short-acting injectables, and the gels are applied daily without need for injection.

64. However, the unit costs of these newer drugs remain much higher than those of the older short acting injectables. Although product expense is not an issue for men receiving NHS prescriptions, it can be a major one for men receiving private prescriptions – or who are illegally buying without prescription from dealers (online or in their local gym). Therefore, these individuals tend to use the much cheaper short-acting injectable forms of Testosterone instead.

65. Hypogonadal men treated with short-acting injectables typically require an intramuscular injection of 250mg every 2–3 weeks, or 100mg every 7–14 days, although men who are abusing testosterone for the purpose of improving athletic performance, getting prominent musculature, or achieving that elusive 'beach body ready six-pack' will inject more frequently in order to consistently maintain serum testosterone concentrations at the top of the male reference range, or indeed above it.

66. A recent retrospective study of transgender males in the USA found that subcutaneous injections of a short-acting testosterone were better tolerated and

achieved more stable serum levels than was possible via the licensed intramuscular route.

67. In men with hypogonadotropic hypogonadism (HH) and preserved underlying testicular function, hCG injected subcutaneously 2–3 times a week is able to normalise testosterone levels by stimulating endogenous secretion by the testes. Advantages over direct testosterone replacement include better preservation of fertility and testicular volume; the main disadvantage being a significantly greater risk of oestrogen-mediated gynaecomastia. However, there is no longer a reliable NHS supply of Pregnyl® in the UK, with physicians and pharmacists having to choose between Ovitrelle® – a drug having UK product-license only for women – and Gonasi®, which has a license for men in Italy and other continental European countries, but not in the UK.

68. Dr Quinton emphasised the importance of distinguishing between the medical need for HH men desiring fertility to be converted from testosterone to hCG therapy, and the body-builders' technique of 'stacking' (described in paragraph 75), wherein hCG is used by men who are abusing (or being inappropriately prescribed) testosterone in an attempt to mitigate testosterone-induced testicular shrinkage and infertility.

### **Principles of testosterone treatment in hypogonadal men**

69. Dr Quinton opined other things being equal, the aim of Testosterone therapy is to achieve serum testosterone levels in the mid-normal range in men using transdermal gels and, for men using injectable Testosterone, levels taken at the pre-injection 'trough' at the lower-end of the normal range.

70. However, the following factors should prompt the treating physician to achieve slightly higher serum testosterone levels in their patients:

- Anaemia
- Osteoporosis, or osteopaenia
- High levels of SHBG
- Persisting sexual dysfunction, fatigue, or vasomotor symptoms

71. Conversely, the development of erythrocytosis or polycythaemia (Hb or Hct above male reference range) should prompt a reduction in Testosterone dose (or its frequency of injection) – even if serum testosterone levels appear satisfactory at first sight – so as to minimise the 50% excess risk of coronary artery thrombosis that is associated with higher haematocrit values.

72. Although glandular gynaecomastia is a feature of untreated hypogonadism –resulting from relative deficiency of testosterone versus oestradiol concentrations – it is paradoxically also a feature of overtreatment with (or far more commonly abuse of) testosterone. It is presumed that persistent supraphysiological testosterone concentrations effectively saturate the 5, alpha-reductase-mediated metabolism of testosterone to its more potent metabolite dihydrotestosterone, with the excess testosterone consequently diverted along the alternative aromatase

pathway of metabolism to oestradiol. This is one reason why men who set out to abuse testosterone may also take aromatase inhibitors or SERMs (selective oestrogen receptor modulator) drugs in order to reduce oestrogen production or action, respectively.

73. Although exogenous testosterone typically suppresses spermatogenesis in normal men, this is not a relevant issue for hypogonadal men, in whom fertility has typically already been lost. Nevertheless, an increasing number of couples present to NHS Fertility clinics as a result of the male partner having lost his spermatogenesis due to abuse of testosterone or anabolics.

#### **The doctors who typically initiate testosterone prescribing to men in the UK.**

74. Dr Quinton described there having been an explosion in testosterone scripts in the UK and elsewhere over the past 20 years; although this may partly represent previously unmet need, a significant proportion was likely to have arisen from inappropriate, ill-informed, or off-label prescribing.

75. Finally, Dr Quinton opined the abuse of testosterone is no longer restricted to elite male athletes wishing to win an Olympic medal, but is now virtually a mainstream activity in the 'Men's Health' community, for the purpose of achieving a more "*sculpted*" body, with better muscle definition and sometimes the desire for improved sexual desire and performance.

#### **Characteristic patterns of prescription drug use accompanying testosterone abuse**

76. Testosterone abusers started off with normal endogenous testosterone secretion and testicular function prior to starting on testosterone. Thus, in order to achieve personal aims in respect of body image or function, they necessarily have to inject testosterone more frequently than would normally be required for replacement therapy in a man with organic hypogonadism. The high serum testosterone concentrations thereby achieved will necessarily suppress secretion of LH & FSH by the pituitary gland, resulting in loss of endogenous testosterone secretion, suppression of spermatogenesis and shrinkage of the testes. Red blood cell production also increases, thereby giving an abnormally high Hb or Hct.

77. Dr Quinton's evidence was that men who abuse testosterone – whether in isolation or with inappropriate medical facilitation – readily share their strategies online for attempting to deal with unwanted effects, including:

- hCG treatment to mitigate loss of testicular volume and fertility – either contemporaneously ('stacking'), or intercalated between cycles of testosterone use (post-cycle therapy, or PCT).
- regularly volunteering to donate blood, so as to reduce the haematocrit back to normal.
- use of aromatase inhibitors (oestrogen blockers licensed for women with ER+ breast cancer), or SERMs (Tamoxifen, or Clomiphene).
- licensed for women with ER+ breast cancer and anovulatory infertility, respectively) to mitigate testosterone-induced reductions in testicular

volume and fertility and/or mitigate testosterone/hCG-induced gynaecomastia.

78. Despite all these strategies, men who have abused testosterone (or anabolics) for long periods are at risk of developing a sustained shut-down of their endogenous reproductive axis. This may require over a year's complete abstinence from exogenous androgens to fully recover. During this period, men may suffer the spectrum of hypogonadal symptoms and signs, including sexual dysfunction, vasomotor sweating and flushing, emotional lability, fatigue and infertility, but testosterone treatment should be avoided if at all possible because it necessarily extends the period of androgen-induced hypogonadism that much further; testosterone treatment should only be considered in extremis, as a short-term measure and in a reducing-dose regimen.

### **Testosterone Deficiency Syndrome (TDS)**

79. Dr Quinton explained that TDS is a term of relatively recent coinage that is not recognised as a medical condition or diagnosis in mainstream endocrinology in the UK. In Dr Quinton's opinion the concept of TDS has been propagated by non-mainstream practitioners and enthusiasts in the UK, as justification for their potentially inappropriate prescription of testosterone drugs to men lacking a properly-validated diagnosis of hypogonadism. In Dr Quinton's experience, the 'diagnosis' of TDS and the ensuring provision of prescriptions for testosterone are usually based on unsound diagnostics, with one or more of the following errors of clinical practice being usually evident:

- Blood tests for testosterone concentration are not taken; the diagnosis is instead based upon client responses to a questionnaire (none of which have adequate specificity).
- Blood tests for testosterone concentration are taken under inappropriate conditions (non-fasted, or in the afternoon), when levels may be 'below range' as a perfectly normal physiological phenomenon.
- A confirmatory blood test for testosterone level is not ordered, with the diagnosis of hypogonadism being inappropriately based upon just a single low testosterone result.
- The patient or client is suffering from a non-gonadal illness, when testosterone concentrations may be 'below range' as a perfectly normal physiological phenomenon; the evolutionary basis for this potentially arising from the need to reallocate the body's scarce resources from reproduction towards survival. However, clients are instead encouraged to believe that they have TDS and that testosterone treatment will improve symptoms, which would be better alleviated by instead addressing the particular non-gonadal illness.
- The patient or client is encouraged to believe that the measured serum testosterone level – through within normal range – somehow too low for them, and that achieving a far higher level through prescribed testosterone will make them feel vastly better.
- The patient or client is encouraged to believe that he harbours a cellular defect of testosterone uptake, whereby testosterone fails to get into the cells

in sufficient quantities to achieve its normal biological action. No such medical condition exists.

- The patient or client is encouraged to believe that testosterone is an anti-ageing '*elixir of life*', which will allow him to recapitulate the physical and sexual vigour of his youth.
- The patient or client is discouraged from considering alternative explanations for their unwanted symptoms, such as life-stresses, unrealistic expectations of libido or sexual performance, underlying non-gonadal medical conditions such as primary depression or anxiety, and unhealthy or sedentary lifestyles.

### **The Tribunal's Analysis of the Evidence and Findings in relation to Androgen Treatment for Male Patients - A-R (Paragraphs 1-63 of the Allegation)**

80. The Tribunal has considered each outstanding paragraph and sub-paragraph of the Allegation separately and has evaluated the evidence in order to make its own findings on the facts.

81. The Tribunal noted that the majority of the allegations in relation to Patient A-R concerned failures to provide 'good clinical care' to those patients. Accordingly, it was necessary, in its consideration of the allegations, for the Tribunal to consider the nature and extent of Dr Webberley's duties in relation to this cohort of patients and the care that he was providing them.

82. For this purpose the Tribunal was informed by Good Medical Practice (2013) ('GMP') and relevant supplemental guidance and the expert opinion evidence of Dr Quinton, with regard to the standard of care to be expected of a reasonably competent consultant physician providing care and treatment for patients with hypogonadism.

#### **Patient A**

83. In respect of this patient, the Tribunal did not have direct evidence from Patient A, but it did have medical records provided by BMH and some patient contact notes from MHC relating to Patient A.

#### **Paragraph 1a of the Allegation**

1. Between 12 April 2017 and on or around 3 August 2018, you failed to provide good clinical care to Patient A in that you:
  - a. did not hold a consultation with Patient A; **Found proved**

84. Dr Quinton's evidence was that there are essentially three elements to the diagnosis of hypogonadism. In no particular order, there is: the taking of an adequate patient history; the taking of blood tests, in particular, relating to testosterone levels and FSH and LH, and a consultation with the patient, which may or may not include a physical examination, but which at the very least provided the doctor an opportunity to see the patient 'face-to-face', either in person or remotely

via video link. In this context, the Tribunal did not consider that correspondence as between a doctor and his patient, whether by email or otherwise, could properly in this context constitute a 'consultation'.

85. In relation to the need for a consultation, Dr Quinton explained that a consultation was necessary for a number of reasons, not least of which is the need to ensure that the patient was seeking testosterone treatment for a *bona fide* medical condition, as opposed to, for the purpose of achieving other perceived benefits of testosterone, namely, a more '*sculpted*' body, better muscle definition and sometimes a wish for improved sexual desire and performance. Dr Quinton's evidence was that by '*eyeballing*' the patient it is sometimes immediately obvious that they are unlikely to be hypogonadal, for example, from their evidently muscular physique. The Tribunal accepted Dr Quinton's evidence in this regard.

86. In relation to Patient A, the Tribunal determined that there was nothing in the BMH medical records produced for this patient to suggest Dr Webberley had spoken to him, much less seen him face-to-face, or had a consultation with him. The only interaction between Dr Webberley and Patient A was online and was limited to a patient questionnaire purportedly completed by Patient A, and an electronically signed and submitted consent document. The records also included a one-page patient summary electronically signed by Dr Webberley, dated 5 July 2017, but in respect of which there was no indication that it had been prepared following any consultation with the patient. However, the Tribunal noted that within the patient summary was a reference to 'diabetes treated with metformin'. The questionnaire did not mention either diabetes or metformin and therefore it was unclear where this information had been obtained by Dr Webberley, if indeed it had been obtained by him personally, or how. Nevertheless, the Tribunal did not consider that this unexplained entry indicated that a consultation was held.

87. Accordingly, the Tribunal found paragraph 1a of the Allegation proved.

#### Paragraphs 1bi, ii and iii of the Allegation

1. Between 12 April 2017 and on or around 3 August 2018, you failed to provide good clinical care to Patient A in that you:
  - b. did not elicit an adequate medical history from Patient A, in that you did not elicit details of:
    - i. sexual symptoms; **Found proved**
    - ii. non-sexual symptoms; **Found proved**
    - iii. answers to general health questions concerning the presenting complaint; **Found proved**

88. Dr Quinton identified one of the other central elements of diagnosing hypogonadism as being the obtaining of an adequate medical history from the patient. A clinical suspicion that a patient may be hypogonadal will arise when it is

identified that the patient has an impairment of a number of different functions, for example; fertility and testicular volumes, libido (sex drive and sexual function), bone density and strength, red blood cell production. Such identification is essential not only to confirm a diagnosis, but also, importantly, to identify the sub-type of hypogonadism i.e. the cause of the testosterone deficiency which will necessarily determine the direction of the further investigation and treatment. Generally, a low testosterone level with abnormally raised LH and FSH levels will indicate a disorder of the testes. Conversely, a low testosterone level with low LH and FSH levels will be consistent with a disorder of the pituitary or a number of other possible scenarios. In order for a doctor to exercise clinical judgement in this regard, the Tribunal accepted that it is necessary for them to evaluate multiple strands of patient related information, such as can only be obtained from an adequate medical history and investigations.

89. In relation to Patient A, the medical records demonstrated that the only medical history that Dr Webberley had was an online questionnaire with a series of tick boxes to enable the patient to indicate; 'yes' or 'no', to such matters as 'health habits and personal safety', 'mental health', the presence or absence of particular symptoms and 'quality of life assessment' coupled with the opportunity for the patient (if they so chose) to provide further detail in respect of those questions they had answered in the affirmative. Although Dr Quinton doubted the utility of this questionnaire, his criticism was not so much directed at the questions themselves, but rather, that Dr Webberley failed to ask directed follow up questions that 'drilled down' or expanded on relevant sexual features (reduced libido, erectile dysfunction, and loss of waking erection) and non-sexual features (anaemia, osteoporosis, gynecomastia and sweating and flushing), potentially related to hypogonadism. It could only be through further enquiry that the doctor would be able to form a proper clinical judgement as to the probable cause of the symptoms.

90. The Tribunal accepted that the medical history, limited as it was to the answers given in the online health questionnaire, was inadequate in that it failed to elicit details of sexual and non-sexual symptoms and the answers given to general health questions concerning the presenting complaint as identified by Dr Quinton.

91. Accordingly, the Tribunal found paragraphs 1b, ii and iii of the Allegation proved.

#### Paragraph 1c of the Allegation

1. Between 12 April 2017 and on or around 3 August 2018, you failed to provide good clinical care to Patient A in that you:

c. did not perform any physical or mental health examination;  
**Found not proved**

92. The Tribunal considered that in the context of this allegation, the phrases 'physical examination' and 'mental health examination', meant something more than that which may have been observed by the doctor by simply looking, at or speaking to, the patient whether in the context of a consultation or otherwise. In

this context, Dr Quinton's evidence was that a patient presenting with suspected hypogonadism may or may not require a physical/mental health examination depending on the circumstances and, in particular, the patient's presentation and visual appearance.

93. The Tribunal, having found that there was no 'consultation', and there being no evidence as to whether this would have indicated that a physical/mental health examination was required, it could not conclude one way or another whether Dr Webberley should have conducted a physical/mental health examination as alleged.

94. Accordingly, the Tribunal found paragraph 1c of the Allegation not proved.

#### Paragraphs 1di and ii of the Allegation

1. Between 12 April 2017 and on or around 3 August 2018, you failed to provide good clinical care to Patient A in that you:

d. inappropriately diagnosed Patient A with hypogonadism in that:

i. the diagnosis was not supported by laboratory results;

**Found proved**

ii. you failed to consider any alternative diagnosis;

**Found proved**

95. Dr Quinton explained that men who lack endogenous testosterone secretion and sperm production, either in whole or in part, are said to have hypogonadism. Accordingly, in the Tribunal's judgement, where Dr Webberley identified a 'testosterone deficiency' and/or 'low testosterone' and/or prescribed testosterone drugs, he was diagnosing hypogonadism in all but name.

96. Dr Quinton gave evidence in relation to a term of relatively recent coinage, namely, Testosterone Deficiency Syndrome 'TDS'. However, as previously set out, he confirmed in his report and in oral evidence that this was not a recognised medical condition or diagnosis amongst mainstream endocrinologists in the United Kingdom. In his expert opinion, the concept of TDS had been propagated by non-mainstream practitioners as a justification for potentially inappropriate prescription of testosterone to men lacking a proper diagnosis of hypogonadism. Accordingly, in the Tribunal's judgement, any diagnosis of TDS would be meaningless and could not justify the prescription of testosterone.

97. In relation to paragraph 1di, Patient A had three blood tests performed, respectively, 27 March 2017, 10 April 2017 and 10 May 2017, following which Dr Webberley prescribed testosterone. According to the patient summary sheet, Dr Webberley recorded "*borderline low total*" [testosterone] and "*low free* [testosterone] *with symptoms*".

98. The evidence of Dr Quinton was that the tests on 27 March 2017 and 10 April 2017 were overwhelmingly more likely to be consistent with normal levels of testosterone. It was his evidence that Dr Webberley must have been aware of the results of these tests as they were recorded in the patient summary form. The Tribunal inferred that the tests had been obtained at Dr Webberley's request. With regard to the test performed on 10 May 2017, Dr Quinton also stated that the testosterone levels were normal and, although no reference to this blood test was made in Dr Webberley's patient summary, a photograph of this laboratory result was within Patient A's BMH records.

99. Accordingly, given that the blood tests unequivocally demonstrated that Patient A was not hypogonadal, the Tribunal found paragraph 1di of the Allegation proved.

100. In relation to paragraph 1dii, the Tribunal accepted Dr Quinton's opinion that, in the light of an absence of any evidence of hypogonadism, Dr Webberley should have considered a differential diagnosis, such as 'androgen seeking behaviour' against a background of significant mental health issues. This was particularly so as Dr Quinton had observed that, at the outset of the questionnaire, Patient A had indicated that the type of treatment he was seeking was balanced TRT with hCG (Human Chorionic Gonadotropin) and oestrogen control (a treatment regime that Dr Quinton opined would be typically described as 'stacking'). Also, from the answers given in Patient A's questionnaire there was evidence of symptoms and problems suggestive of a person who was vulnerable and who might have had mental health issues.

101. Accordingly, the Tribunal found paragraph 1dii of the Allegation proved.

#### Paragraphs 1ei, ii and iii of the Allegation

1. Between 12 April 2017 and on or around 3 August 2018, you failed to provide good clinical care to Patient A in that you:
  - e. prescribed testosterone, Human Chorionic Gonadotropin ('hCG') and anastrozole which was:
    - i. not clinically indicated; **Found proved**
    - ii. unsafe; **Found proved**
    - iii. not recognised as therapeutic practice in medicine; **Found proved**

102. In relation to paragraph 1ei, in Dr Quinton's expert opinion, which the Tribunal accepted, even if hypogonadism had been the correct diagnosis (which it was not) the treatment regime prescribed, in terms of type of medication, frequency and dosage, was not one that would be recognised in mainstream endocrinology in the United Kingdom but rather, as Dr Quinton termed it, a '*body builders' cocktail*', namely a treatment regime based upon protocols devised by

body builders rather than derived from clinical evidence and specialist medical guidance. None of the drugs prescribed for Patient A were clinically indicated, either alone or in combination, such that their prescription was completely inappropriate.

103. Accordingly, the Tribunal found paragraph 1ei of the Allegation proved.

104. In relation to paragraph 1eii, in oral evidence Dr Quinton stated that there was no long-term safety data regarding what happens to men who have normal testosterone levels to begin with and who have then been started on high dose testosterone and other additional therapies. However, quite apart from this fact, Dr Quinton's evidence was that excessive doses of testosterone are associated with serious risks, these include erythrocytosis (increase in number of red blood cells), risks of a venous thrombo-embolism, myocardial infarction, stroke and growth of pre-existing prostate cancer amongst other things. Furthermore, in Dr Quinton's opinion Patient A, who had pre-existing normal levels of testosterone, was being prescribed double the dose of testosterone that one would expect for a man with hypogonadism. In the Tribunal's judgement, given the risks associated with excessive levels of testosterone, and the doses which Dr Webberley was prescribing Patient A, it was self-evidently both unsafe and unnecessary to do so.

105. Accordingly, the Tribunal found paragraph 1eii of the Allegation proved.

106. In relation to paragraph 1eiii, the Tribunal accepted the evidence of Dr Quinton that the treatment regime prescribed was not in accordance with national and international guidelines, none of which would endorse this treatment regime.

107. Accordingly, the Tribunal found paragraph 1eiii of the Allegation proved.

#### Paragraph 1f of the Allegation

1. Between 12 April 2017 and on or around 3 August 2018, you failed to provide good clinical care to Patient A in that you:

f. did not conduct tests adequately; **Found not proved**

108. The context of this allegation was that Dr Webberley failed to conduct pre-diagnostic/treatment tests adequately in relation to the tests performed on 27 March 2017, 10 April 2017, and 10 May 2017. Dr Quinton's criticism with the adequacy of these tests was two-fold. Firstly, that Dr Webberley had failed to specify the timing of the taking of venepuncture and that it should be fasted, which would potentially impact upon the interpretation of the resultant testosterone levels shown. Secondly, that Dr Webberley had not (in relation to the first two tests) sought LH and FSH levels which Dr Quinton said are central to the 'work up' of suspected hypogonadism. Although the Tribunal acknowledged that Dr Quinton's criticisms of the adequacy of these tests might well be valid, it did not accept Dr Quinton's underlying premise that it had been Dr Webberley who had been responsible for obtaining these three tests. The Tribunal considered that Dr Quinton's analysis of the chronology from the medical records was in error.

109. Dr Quinton, for reasons which were unclear, but which may have been his having mistaken facts for Patient A for Patient B, inferred that Patient A had been under Dr Webberley's care from 12 April 2017. However, in the Tribunal's judgement, the evidence suggested that it had not been until, on or around the 29 June 2017, that Patient A became Dr Webberley's patient. It was 29 June 2017 when Patient A completed BMH's online questionnaire and electronically signed various forms relating to the agreement with BMH medical consent and consent for testosterone replacement therapy. Notably, within the online questionnaire Patient A indicated that within the last 6-12 months he had had more than two blood tests for testosterone. The Tribunal concluded from this that the three pre-diagnostic/treatment tests, which were the subject of the Allegation at 1f, had been requested and undertaken prior to Patient A becoming Dr Webberley's patient. It followed therefore that Dr Webberley could not properly be criticised for the adequacy of the same.

110. The Tribunal was mindful of the fact that the evidence suggested Dr Webberley had sought further blood tests following the 'diagnosis' and prescription of testosterone. However, the purpose of these was to monitor the effects of the treatment and they were not diagnostic, and Dr Quinton's criticisms of the adequacy of the tests performed in a diagnostic context did not apply.

111. In reaching this conclusion, the Tribunal acknowledged that Dr Webberley might have been criticised for failing to obtain any pre-diagnostic/treatment tests himself. However, this was not the Allegation, and the Tribunal did not consider that it would be appropriate to amend the Allegation of its own motion, particularly having regard to the fact that Dr Webberley was neither present nor represented.

112. Accordingly, the Tribunal found paragraph 1f of the Allegation not proved.

#### Paragraph 1g of the Allegation

1. Between 12 April 2017 and on or around 3 August 2018, you failed to provide good clinical care to Patient A in that you:

g. inappropriately relied on non-medically trained members of staff to review results of Patient A's blood tests;

**Found not proved**

113. Having had regard to all the available medical records, the Tribunal could find no evidence that the test results had been reviewed at all, much less that they had been reviewed by non-medically trained members of staff. Further, the Tribunal was unable to conclude that Dr Webberley had 'relied' upon BMH staff to review the test results.

114. Again, as the Tribunal found in respect of paragraph 1f, it may be that Dr Webberley could be criticised for not reviewing the blood tests himself. This was particularly so given that the post-prescription blood tests suggested anaemia and excessive levels of testosterone, which Dr Quinton opined should have been acted on.

115. However, for the same reasons given in respect of paragraph 1f above, the Tribunal did not consider it appropriate to amend the Allegation in this regard.

116. Accordingly, the Tribunal found paragraph 1g of the Allegation not proved.

#### Paragraph 1h of the Allegation

1. Between 12 April 2017 and on or around 3 August 2018, you failed to provide good clinical care to Patient A in that you:
  - h. did not communicate at all with Patient A during the course of his treatment; **Found not proved**

117. Following a review of BMH's medical records in relation to Patient A, the Tribunal found that there was no direct evidence of any communication between Patient A and Dr Webberley subsequent to the prescription of testosterone on 5 July 2017.

118. However, there was evidence that, on no fewer than four occasions, Patient A had blood tests performed between 18 October 2017 and 8 May 2018, as previously indicated there was no evidence that these tests were reviewed or even discussed with Patient A. Nevertheless, the Tribunal inferred that there must have been some communication between BMH and Patient A for these blood tests to have been performed and the results communicated to BMH. The Tribunal did not consider that the GMC had proved, on the balance of probabilities, that it was not Dr Webberley who had communicated with Patient A in this respect.

119. Therefore, the Tribunal concluded that it was not satisfied that there had been no communication 'at all' between Dr Webberley and Patient A.

120. Accordingly, the Tribunal found paragraph 1h of the Allegation not proved.

#### Paragraph 1i of the Allegation

1. Between 12 April 2017 and on or around 3 August 2018, you failed to provide good clinical care to Patient A in that you:
  - i. did not provide adequate follow up care in that you failed to arrange a follow-up consultation with Patient A after treatment had commenced; **Found proved**

121. The Tribunal, having reviewed BMH's medical records in relation to Patient A, found no evidence to suggest that Dr Webberley had arranged or sought to arrange any follow-up consultation with Patient A after treatment had commenced. Notwithstanding the fact that the monitoring blood tests performed in the months following the commencement of treatment plainly required action by Dr Webberley and, at the very least, a consultation with Patient A.

122. The Tribunal considered the possibility that Dr Webberley may have sought to arrange a consultation with Patient A, but such efforts were not recorded in Patient A's medical record. However, the Tribunal considered it more probable that in fact no attempts were made to arrange a follow-up consultation by Dr Webberley for the following reasons:

- a) There was evidence of communication between Dr Webberley and Patient A prior to the prescription of testosterone on 5 July 2017;
- b) The prescription of 5 July 2017 was a prescription intended to be repeated five times, this was in itself surprising given that it was a first prescription and Dr Webberley would have had no way of knowing what subsequent blood tests would have shown;
- c) Thereafter, there was no communication in the record between Patient A and Dr Webberley, and as the Tribunal had already observed, no evidence that Dr Webberley had reviewed the subsequent monitoring blood tests despite an obvious necessity to do so.

123. In these circumstances, the Tribunal concluded that Dr Webberley had not sought to arrange a follow-up consultation as he should have done.

124. Accordingly, the Tribunal found paragraph 1i of the Allegation proved.

#### Paragraph 1j of the Allegation

1. Between 12 April 2017 and on or around 3 August 2018, you failed to provide good clinical care to Patient A in that you:
  - j. did not respond to follow-up blood tests which indicated over-treatment. **Found proved**

125. The Tribunal considered that given the very high levels of testosterone recorded in the monitoring blood tests for Patient A, and on the basis of the expert opinion of Dr Quinton, the results of these tests plainly required a response by Dr Webberley.

126. For the same reasons the Tribunal found in respect of paragraph 1i, the Tribunal found paragraph 1j of the Allegation proved.

#### Paragraphs 2a and bi, ii, iii and c of the Allegation

2. The Participation Agreement & Informed Consent Form and the Consent for Testosterone Replacement Therapy Form ('the Consent Forms') provided to Patient A stated that:
  - a. the higher limit of normal testosterone range was 40 nmol/L; **Found proved**

- b. untreated hypogonadism can increase the risk of:
  - i. heart disease; **Found proved**
  - ii. Alzheimer's disease; **Found proved**
  - iii. premature death; **Found proved**
- c. the treatment provided was 'TRT' (testosterone replacement therapy). **Found proved**

127. The Tribunal had regard to the Participation Agreement & Informed Consent Form and the Consent for Testosterone Replacement Therapy Form, which detailed the above factual statements ('the Consent Forms') signed by Patient A on 29 June 2017.

128. Accordingly, the Tribunal found paragraphs 2a and bi, ii, iii and c of the Allegation proved.

#### Paragraph 3a of the Allegation

- 3. You knew that the information in the Consent Form was untrue as:
  - a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **Found proved**

129. Dr Quinton's expert opinion, which the Tribunal accepted, was that the higher (upper) limit of normal testosterone was in the region of 30 nmol/L. Further, this opinion was borne out by a number of laboratory blood test results that demonstrated that the higher (upper) normal range varied from 30.0 – 31.4 nmol/L in different laboratories. Dr Quinton opined that the 40 nmol/L higher (upper) limit quoted in the consent form was way above that which would be regarded as normal.

130. The Tribunal concluded from the evidence before it that Dr Webberley must have been familiar with laboratory blood test results and the normal ranges quoted therein. Accordingly, the Tribunal determined that Dr Webberley must have known that the higher (upper) limit quoted in BMH's consent form was untrue.

131. Accordingly, the Tribunal found paragraph 3a of the Allegation proved.

#### Paragraphs 3bi, ii and iii of the Allegation

- 3. You knew that the information in the Consent Form was untrue as:
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **Found not proved**

ii. Alzheimer's disease; **Found not proved**

iii. premature death; **Found not proved**

132. In relation to paragraph 3bi, the evidence of Dr Quinton was that there was an issue with regard to patients with 'genuine' hypogonadism as to whether exogenous testosterone increases the risk of heart disease or reduces the risk. Some studies have suggested the former, others have suggested the latter and Dr Quinton opined 'the jury is still out'.

133. In these circumstances, the Tribunal considered that it could not be satisfied that the statement at 3bi was untrue.

134. Accordingly, the Tribunal found paragraph 3bi of the Allegation not proved.

135. In relation to paragraphs 3bii and 3biii, Dr Quinton's evidence, which the Tribunal accepted, was unequivocal and that there was no data or evidence to suggest that untreated hypogonadism increased the risk of either Alzheimer's disease or premature death. Therefore, the Tribunal concluded that the statements in 3bii and 3biii were untrue.

136. The Tribunal went on to consider whether, in respect the statements at 3bii and 3biii, Dr Webberley knew that they were untrue. The Tribunal considered that there were only two realistic possibilities. Firstly, the statements were untrue, and Dr Webberley knew them to be untrue. Secondly, the statements were untrue, but Dr Webberley believed them to be true.

137. The Tribunal had no evidence as to the author of the consent form, or indeed as to the source of the information therein. Taking the evidence at its highest, the Tribunal could only conclude that this was a document used by Dr Webberley in relation to the treatment of the patients at BMH and that it could be inferred that he knew of the contents. The Tribunal considered that this was an insufficient basis for it to infer, on the balance of probabilities, that he must have known that some of the statements within the consent form were untrue.

138. In reaching this conclusion the Tribunal was mindful of the fact that it was the GMC's case that Dr Webberley lacked relevant qualification and experience in endocrinology, and if this was correct, the Tribunal did not consider that it could be inferred that he would have necessarily known of the inaccuracy of the statements at 3bii and 3biii.

139. Accordingly, the Tribunal found paragraphs 3bii and 3biii of the Allegation not proved.

#### Paragraph 3c of the Allegation

3. You knew that the information in the Consent Form was untrue as:

- c. the treatment to be provided would increase testosterone above normal limits and was not TRT. **Found not proved**

140. Initially, Dr Quinton's evidence in this regard was that the treatment that was to be provided to Patient A could not be regarded as Testosterone *Replacement* Therapy (TRT) because the purpose was to prescribe exogenous testosterone to a patient with normal endogenous testosterone levels. Therefore, Dr Webberley would not have been 'replacing' testosterone but rather would have been 'increasing' testosterone beyond normal limits. However, following Tribunal questions Dr Quinton conceded that he might be regarded as being 'pernickety' in expressing this view. He seemingly accepted that although Dr Webberley was not literally providing replacement therapy, the phrase 'TRT', used in the vernacular, could not be criticised. Dr Quinton was to say that endocrinologists, latterly, more frequently use the phrase testosterone therapy (TT). The Tribunal found paragraph 3c not proved.

#### Paragraph 4 of the Allegation

4. Your conduct as set out at paragraph 2 was dishonest by reason of paragraph 3. **Found proved in relation to 2a by reason of 3a**

141. The Tribunal, having determined that paragraphs 2a and 3a were proved, went on to consider whether Dr Webberley's conduct was dishonest in this regard. The Tribunal determined that Dr Webberley, in using a consent form that he knew falsely stated the higher limit of normal testosterone to such an excessive degree was self-evidently dishonest and would be regarded as such by the standards of ordinary decent people.

142. In particular, the Tribunal considered that the only purpose which Dr Webberley could have had in knowingly making this untrue statement, would have been to either, in due course, mislead his patient into believing that he had a medical condition requiring treatment, namely hypogonadism and that TRT/TT was necessary or, alternatively to create the impression to others that he was providing treatment to Patient A for a *bona fide* medical condition as opposed to prescribing inappropriately for the purpose of, for example, 'body sculpting' or enhanced athletic performance.

143. In reaching this conclusion, the Tribunal considered it significant that within the consent form not only was the upper limit of normal testosterone range inflated, it was also stated that to obtain the full benefits of testosterone, the purpose of the therapy was to restore testosterone levels to the 'optimal' range and not the 'normal for age' range. This specifically meant potentially raising the patient's testosterone level to the higher (upper) quarter of the untruthful reference range, stated to be 24/40 nmol/L.

144. Accordingly, the Tribunal therefore found paragraph 4 in relation to 2a by reason of 3a of the Allegation proved.

#### Paragraphs 5a and b of the Allegation

5. You did not obtain informed consent from Patient A for treatment you provided in that:
  - a. you failed to counter-sign the Consent Forms;  
**Found not proved**
  - b. the Consent Forms contained statements which were untrue.  
**Found proved**

145. In relation to paragraph 5a, the Tribunal found this allegation not proved. The Tribunal did not consider that a failure of Dr Webberley to counter-sign the consent form could have had any impact on whether Patient A's consent to treatment was informed or not, a proposition accepted by Dr Quinton during oral evidence.

146. The Tribunal, having concluded that the consent form provided untruthful information, both in relation to the risks associated with untreated hypogonadism, and as to the normal higher (upper) limits of testosterone, determined that Patient A could not have provided informed consent on the basis of the contents of this document. Rather, any consent obtained would have been misinformed.

147. Accordingly, the Tribunal found paragraphs 5a of the Allegation not proved and 5b of the Allegation proved.

### **Patient B**

148. In respect of this patient, the Tribunal did not have direct evidence from Patient B, but it did have the medical records provided by BMH and some patient contact notes from MHC relating to Patient B.

### **Paragraph 6a of the Allegation**

6. Between ~~15 June 2017~~ 22 March 2017 and 17 September 2018, you failed to provide good clinical care to Patient B in that you:
  - a. did not hold a consultation with Patient B; **Found proved**

149. The Tribunal noted that Patient B had previously received testosterone treatment from BMH in December 2015 and was, as Dr Quinton described it '*a return customer*'. However, the Tribunal found no evidence to suggest that it had been Dr Webberley who provided the previous care of Patient B.

150. In all other respects the interaction between Patient B and BMH and the care Patient B received from them was very similar to that of Patient A. Although the Tribunal noted that, in respect of Patient B, BMH had sought a pre-diagnosis/treatment blood test and also, following the prescription of testosterone by Dr Webberley, there was evidence of communication between

Patient B and a Mr MK of BMH, a non-medically qualified employee with the title 'Director/Medical Facilitator'.

151. Apart from these differences, the Tribunal determined that there was no relevant distinction to be made between the cases of Patient A and B and the requirement to hold a consultation with Patient B. Accordingly, for the same reasons as outlined in relation to paragraph 1a, the Tribunal found paragraph 6a proved.

152. In reaching this conclusion, the Tribunal acknowledged that there had been some indirect communication as between Patient B and Dr Webberley via Mr MK who had, on 5 June 2017, copied Dr Webberley into an email he had sent to Patient B in which he (Mr MK) recorded a telephone conversation with Patient B who had not noticed any benefit from the treatment prescribed, despite recent blood tests showing a rise in testosterone levels. However, this single email was the only communication appearing in Patient B's medical record and did not indicate in any way that a consultation with Dr Webberley had been or would be held in the future.

153. Accordingly, the Tribunal found paragraph 6a of the Allegation proved.

#### Paragraphs 6bi, ii, iii and iv of the Allegation

6. Between ~~15 June 2017~~ 22 March 2017 and 17 September 2018, you failed to provide good clinical care to Patient B in that you:
  - b. did not yourself elicit an adequate medical history from Patient HO, in that you did not elicit details of:
    - i. sexual symptoms; **Found proved**
    - ii. non-sexual symptoms; **Found proved**
    - iii. answers to general health questions concerning the presenting complaint; **Found proved**
    - iv. details of his treatment for high blood pressure with doxazosin; **Found not proved**

154. In relation to paragraphs 6bi, ii and iii, the Allegation, unlike that at paragraph 1a, was that Dr Webberley did not *himself* elicit an adequate medical history in respect of the details at paragraphs 6bi to iii and iv. This was in implicit acknowledgement of the fact that some limited medical history had apparently been elicited by the non-medically qualified employee, Mr MK.

155. The Tribunal determined that, for the same reasons as set out in relation to paragraphs 1bi to iii, Dr Webberley, as the medical practitioner responsible for Patient B's care, should have elicited these details and there was no evidence that he had done so. It was not appropriate for a medical history to be taken by a non-medically trained person and Dr Webberley should have done it himself.

156. Accordingly, the Tribunal found paragraphs 6bi, ii and iii proved.

157. In relation to paragraph 6biv, Dr Quinton noted that when Patient B was seen by a doctor at MHC on 17 September 2018, this doctor established Patient B was taking doxazosin for hypertension, a condition which Dr Quinton observed Dr Webberley had failed to elicit when Patient B was under his care. However, the Tribunal determined that there was no evidence as to when Patient B ceased to be a patient of Dr Webberley/BMH, or the date on which Patient B was first diagnosed as being hypertensive and was prescribed doxazosin. In these circumstances, the Tribunal was unable to conclude that Dr Webberley had failed to elicit details of Patient B's treatment for high blood pressure, as alleged in paragraph 6biv. The Tribunal also noted that in the BMH online health questionnaire, Patient B had not indicated that he was at that time taking any prescribed medication.

158. Accordingly, the Tribunal found paragraph 6biv of the Allegation not proved.

#### Paragraph 6c of the Allegation

6. Between ~~15 June 2017~~ 22 March 2017 and 17 September 2018, you failed to provide good clinical care to Patient B in that you:
  - c. did not perform any physical or mental health examination of Patient B; **Found not proved**

159. For the same reasons given in respect of paragraph 1c, the Tribunal found paragraph 6c of the Allegation not proved.

#### Paragraphs 6di and ii of the Allegation

6. Between ~~15 June 2017~~ 22 March 2017 and 17 September 2018, you failed to provide good clinical care to Patient B in that you:
  - d. inappropriately diagnosed Patient B with hypogonadism in that:
    - i. the diagnosis was not supported by laboratory results; **Found proved**
    - ii. you failed to consider any alternative diagnosis; **Found proved**

160. In relation to paragraph 6di and ii, the Tribunal accepted Dr Quinton's evidence that the pre-prescription blood test performed on 23 March 2017 showed a normal testosterone level and 'slightly low' calculated free testosterone but which, in Dr Quinton's opinion, was almost certainly acceptable for a non-fasted and untimed sample. Therefore, the Tribunal concluded that a diagnosis of hypogonadism was not supported by the relevant laboratory results. Further, the Tribunal accepted that, in the absence of evidence of hypogonadism, Dr Webberley should have considered a differential diagnosis for the symptoms which Patient B

reported in his online health questionnaire, for example, a possible diagnosis of erectile dysfunction due to vascular problems related to hypertension (if Patient B was hypertensive at this time) or possibly 'androgen seeking behaviour'.

161. Accordingly, the Tribunal found paragraphs 6di and ii of the Allegation proved.

#### Paragraphs 6ei and ii of the Allegation

6. Between ~~15 June 2017~~ 22 March 2017 and 17 September 2018, you failed to provide good clinical care to Patient B in that you:
  - e. prescribed testosterone which was:
    - i. not clinically indicated; **Found proved**
    - ii. unsafe; **Found proved**

162. With regard to paragraph 6ei, the Tribunal determined that this allegation was proved for the same reason set out in relation to paragraph 1ei.

163. With respect to paragraph 6eii, although Dr Quinton did not specifically express the opinion that the prescription of testosterone to Patient B was unsafe in the same terms as he did with Patient A. He did however observe that the prescription of testosterone would place Patient B at a risk of androgen induced erythrocytosis. The Tribunal inferred that the other risks, identified by Dr Quinton in respect of Patient A, would be present in the case of Patient B as they would be for any patient with normal levels of testosterone who is being prescribed exogenous testosterone.

164. Accordingly, the Tribunal found paragraphs 6ei and ii of the Allegation proved.

#### Paragraph 6f of the Allegation

6. Between ~~15 June 2017~~ 22 March 2017 and 17 September 2018, you failed to provide good clinical care to Patient B in that you:
  - f. did not conduct tests adequately; **Found not proved**

165. In relation to Patient B, BMH's records indicated that two blood tests were obtained by BMH following Patient B's return to BMH in or around late March 2017. The first blood test was a pre-diagnostic/pre-prescription blood test for testosterone and oestradiol, but did not include a test for haemoglobin, haematocrit, or LH and FSH levels. The laboratory result of this test appeared in Patient B's BMH medical record. The second blood test appeared to have been obtained on or around 5 June 2017, after Patient B had been prescribed testosterone on 12 April 2017. The laboratory results of this latter test did not appear in Patient B's medical record. However, it was referenced in the email sent to Patient B by Mr MK on 5 June 2017.

166. Dr Quinton criticised the adequacy of the blood test obtained by BMH in three respects. Firstly, there was no record of a test for haemoglobin and/or haematocrit and in the absence of which Patient B would have been, in Dr Quinton's opinion, at risk of androgen induced erythrocytosis. Secondly, Dr Quinton criticised what appeared to be a failure to order 'baseline' LH and FSH levels which he said were central to the diagnostic 'work up' of suspected hypogonadism. Thirdly, that Dr Webberley, in obtaining the blood test, failed to specify the conditions under which blood should be drawn (fasted and early morning), which could have explained the slightly low free testosterone level, and which could have contributed to a misdiagnosis.

167. With regards to the first criticism, the Tribunal considered that Dr Quinton was postulating the obtaining of haemoglobin/haematocrit test results *after* Patient B had been prescribed testosterone, at which time Patient B might be at risk of androgen induced erythrocytosis. However, the Tribunal had already noted that there was evidence that a blood test was performed, on or around 5 June 2017, but there was no evidence as to what the precise tests were (Mr Mk's email was no more than a precis). Therefore, the Tribunal was unable to conclude, on the balance of probabilities, that haemoglobin/haematocrit tests had not been performed.

168. With regard to the second criticism, the Tribunal did not understand Dr Quinton to be expressing the opinion that, with regard to baseline LH and FSH levels being necessary as central to a diagnostic work up, such tests must necessarily be performed in the first instance, or that it would not be acceptable for a doctor, suspecting hypogonadism, to initially perform a testosterone test alone and, thereafter, if low testosterone was identified, to perform further tests with a view to establishing LH and FSH levels and, therefore, the likely cause of the testosterone deficiency.

169. As to Dr Quinton's final criticism, the Tribunal accepted that there was nothing on the test results obtained from the independent laboratory, on 23 March 2017, to indicate when blood had been drawn or whether it was fasted or unfasted. However, the Tribunal did not consider that it could infer from this fact that Dr Webberley had failed to specify to Patient B, either by himself or through his staff, the conditions under which blood should be drawn. For these reasons the Tribunal found paragraph 6f not proved.

#### Paragraphs 6gi and ii of the Allegation

6. Between ~~15 June 2017~~ 22 March 2017 and 17 September 2018, you failed to provide good clinical care to Patient B in that you:
  - g. did not review Patient B's:
    - i. laboratory test results; **Found not proved**
    - ii. medication; **Found not proved**

170. In relation to paragraph 6gi and 6gii, the Tribunal noted that within Patient B's BMH medical notes there was no record of Dr Webberley having either reviewed Patient B's test results or medication. However, the Tribunal considered that the absence of a record of such reviews did not necessarily establish that no such reviews took place. This was particularly so having regard to the fact that there was some evidence that Mr MK was communicating with Dr Webberley with regard to Patient B's response to treatment, namely, on 5 June 2017, when Mr MK copied Dr Webberley into the email referred to above.

171. Therefore, the Tribunal was not satisfied that Dr Webberley had failed to conduct a review of laboratory test results and/or medication. Although the Tribunal noted that there was no record of Dr Webberley having acted upon any such review. The Tribunal would have expected there to have been a review, in the light of Dr Quinton's evidence as to what Dr Webberley should have done, following receipt of the test result around 5 June 2017.

172. Nonetheless, the Tribunal found paragraphs 6gi and ii of the Allegation not proved.

#### Paragraph 6h of the Allegation

6. Between ~~15 June 2017~~ 22 March 2017 and 17 September 2018, you failed to provide good clinical care to Patient B in that you:

h. inappropriately relied on a non-medically trained member of staff to review Patient B's laboratory results;

**Found not proved**

173. It necessarily followed from the Tribunal's determination in relation to paragraph 6g, that paragraph 6h was not proved because the Tribunal was not satisfied that Dr Webberley had not himself reviewed the laboratory test results.

174. Accordingly, the Tribunal found paragraph 6h of the Allegation not proved.

#### Paragraphs 6i(i) and (ii) of the Allegation

6. Between ~~15 June 2017~~ 22 March 2017 and 17 September 2018, you failed to provide good clinical care to Patient B in that you:

i. did not adequately communicate with Patient B in that you:

i. delegated communications to non-medically trained members of staff when it was inappropriate to do so;

**Found not proved**

ii. failed to maintain regular correspondence;

**Found not proved**

175. The Tribunal noted that the evidence in relation to the care of Patient B relied solely upon the content of Patient B's BMH patient notes provided by BMH to the GMC. It further noted the records were obviously incomplete either because documents that must have existed were not included, or there was an absence of a record of matters that must have occurred. For example, it was evident from the email from Mr MK, on 5 June 2017, that a further blood test and another 'Adams' questionnaire had been completed. Neither the laboratory results of that blood test or the questionnaire was in the record. Furthermore, the email indicated that there had been a telephone conversation between Mr MK and Patient B and yet there was no separate record of that conversation within Patient B's notes.

176. In these circumstances, the Tribunal was unable to draw an inference from an absence of a record within Patient B's notes that the events alleged in paragraph 6i(i) and (ii) had not occurred.

177. Accordingly, the Tribunal found paragraphs 6i(i) and (ii) of the Allegation not proved.

#### Paragraph 6j of the Allegation

6. Between ~~15 June 2017~~ 22 March 2017 and 17 September 2018, you failed to provide good clinical care to Patient B in that you:

- j. did not provide adequate follow up care in that you relied entirely upon email communication between Patient B and non-clinical facilitators. **Found not proved**

178. For the same reasons given in relation to paragraph 6i(i) and (ii), the Tribunal was not satisfied, on the balance of probabilities, that Dr Webberley had 'relied entirely on email communication between Patient B and 'non-clinical facilitators'.

179. Accordingly, the Tribunal found paragraph 6j of the Allegation not proved.

#### Paragraphs 7, 8, 9 and 10 of the Allegation

180. The Tribunal noted that that which is alleged in paragraphs 2, 3, 4 and 5, in relation to Patient A, mirrored that which is alleged at paragraphs 7, 8, 9 and 10, in respect of Patient B. Accordingly, for the reasons which it has already set out above, it found:

- 7. The Consent Forms provided to Patient B stated that:
  - a. the higher limit of normal testosterone range was 40 nmol/L; **Found proved**
  - b. untreated hypogonadism can increase the risk of:
    - i. heart disease; **Found proved**

- ii. Alzheimer's disease; **Found proved**
    - iii. premature death; **Found proved**
  - c. the treatment provided was TRT. **Found proved**
- 8. You knew that the information in the Consent Forms was untrue as:
  - a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **Found proved**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **Found not proved**
    - ii. Alzheimer's disease; **Found not proved**
    - iii. premature death; **Found not proved**
  - c. the treatment to be provided would increase testosterone above normal limits and was not TRT. **Found not proved**
- 9. Your conduct as set out at paragraph 7 was dishonest by reason of paragraph 8. **Found proved (in relation to 7a by reason of 8a)**
- 10. You did not obtain informed consent from Patient B for treatment you provided in that:
  - a. you failed to counter-sign the Consent Forms; **Found not proved**
  - b. the Consent Forms contained statements which were untrue. **Found proved**

### **Patient C**

181. In respect of this patient, the Tribunal did not have direct evidence from Patient C, it did have an incomplete medical record provided by BMH and some patient contact notes from MHC relating to Patient C.

### **Paragraphs 11ai1, 2, 3 and 4 of the Allegation**

- 11. Between 26 July 2017 and 29 June 2018, you failed to provide good clinical care to Patient C in that you:
  - a. consulted with Patient C on 17 August 2017 and failed to:
    - i. elicit an adequate medical history in that you:

1. relied upon details obtained by a non-medically trained member of staff; **Found not proved**
2. failed to elicit details of sexual symptoms; **Found not proved**
3. failed to elicit details of non-sexual symptoms; **Found not proved**
4. failed to ask general health questions concerning the presenting complaint; **Found not proved**

182. In respect of Patient C, the GMC alleged that there was a consultation on 17 August 2017. The Tribunal noted that the only evidence relied upon in support of this allegation was an email from Dr Webberley to Patient C on this date, which followed an email (undated) from Patient C, in which Patient C asked a number of questions relating to his treatment. The Tribunal, having considered the content of both emails, doubted whether the former was a response to the latter, or indeed, whether the emails were sent on the same day as each other. In any event, the Tribunal did not consider that this exchange of emails could, on any view, be described as a consultation. For this reason, the Tribunal found that the stem of paragraph 11a was not proved and necessarily paragraphs 11ai1-4 also not proved.

#### Paragraph 11b of the Allegation

11. Between 26 July 2017 and 29 June 2018, you failed to provide good clinical care to Patient C in that you:
  - b. did not perform any physical or mental health examination; **Found not proved**

183. The Tribunal considered that, whether or not, the circumstances of Patient C's case required Dr Webberley to perform a physical and/or mental health examination, BMH's medical record was so obviously incomplete that the Tribunal was unable to conclude, on the balance of probabilities, that there had been neither a physical nor mental health examinations.

184. Accordingly, the Tribunal found paragraph 11b of the Allegation not proved.

#### Paragraphs 11ci and ii of the Allegation

11. Between 26 July 2017 and 29 June 2018, you failed to provide good clinical care to Patient C in that you:
  - c. inappropriately diagnosed Patient C with hypogonadism requiring long term treatment in that:

- i. the diagnosis was not supported by laboratory results;  
**Found proved**
- ii. you failed to consider any alternative diagnosis;  
**Found proved**

185. Within Patient C's BMH medical records was correspondence between Patient C and an NHS Consultant Endocrinologist, Dr FM Swords, under whose care Patient C had been prior to Patient C contacting BMH. The correspondence disclosed that Patient C had been receiving treatment as a result of having been diagnosed with hypogonadism, secondary to previous testosterone use, and that the NHS doctor had expressed a preference to allow spontaneous recovery (i.e. without prescription of testosterone) but had agreed to treat with the lowest possible dose of testosterone so as to relieve symptoms (in the short term). The Tribunal therefore concluded, in the light of Dr Quinton's expert evidence; a diagnosis with hypogonadism requiring long term treatment was not appropriate, it was not supported by laboratory results, and by prescribing testosterone at a high dose Dr Webberley had evidently failed to consider the alternative diagnosis as had been clearly set out in the correspondence of the previous treating doctor, copies of which BMH had.

186. Accordingly, the Tribunal found paragraphs 11ci and ii of the Allegation proved.

Paragraphs 11di, ii and iii of the Allegation

- 11. Between 26 July 2017 and 29 June 2018, you failed to provide good clinical care to Patient C in that you:
  - d. prescribed testosterone, hCG and anastrozole which was:
    - i. not clinically indicated; **Found proved**
    - ii. unsafe; **Found proved**
    - iii. not recognised as therapeutic practice in medicine;  
**Found proved**

187. In relation to the treatment regime prescribed by Dr Webberley, Dr Quinton acknowledged that there were a number of alternative possible treatments for Patient C's androgen induced hypogonadism. One possibility would have been 'a strictly time limited and tapering-dose course of transdermal testosterone'.

188. However, Dr Webberley prescribed testosterone at a high dose (double the mean average) in combination with anastrozole and hCG, with no attempt to taper over time (the Tribunal noted that the prescription was for a 'repeat five times'). Dr Quinton's evidence was that the doses and combination of drugs prescribed by Dr Webberley were more closely modelled on regimens used by body builders, rather

than for the cessation of androgen induced hypogonadism. Accordingly, the Tribunal determined that Dr Webberley's prescription was neither clinically indicated, nor safe, nor recognised as medically therapeutic in these circumstances.

189. Accordingly, the Tribunal found paragraphs 11di, ii and iii of the Allegation proved.

#### Paragraph 11e of the Allegation

11. Between 26 July 2017 and 29 June 2018, you failed to provide good clinical care to Patient C in that you:

e. did not conduct tests adequately; **Found proved**

190. There was a single post prescription monitoring blood test on Patient C's BMH records, which had not included a full blood count. For the reasons given in relation to Patient B, there should have been full blood counts conducted for monitoring purposes, i.e. because of the risk of androgen induced erythrocytosis associated with the taking of exogenous testosterone.

191. Accordingly, the Tribunal found paragraph 11e of the Allegation proved.

#### Paragraphs 11f, g and h of the Allegation

11. Between 26 July 2017 and 29 June 2018, you failed to provide good clinical care to Patient C in that you:

f. did not review any test results performed during the course of Patient C's treatment; **Found not proved**

g. did not adequately communicate with Patient C;  
**Found not proved**

h. did not provide adequate follow up care in that you failed to arrange a follow-up consultation with Patient C after treatment had commenced. **Found not proved**

192. The Tribunal determined that these paragraphs were not proved as there was no direct evidence of the facts alleged and the Tribunal was unable to draw an inference based upon evidently incomplete medical records.

193. Accordingly, the Tribunal found paragraphs 11f, g and h of the Allegation not proved.

#### Paragraphs 12, 13, 14 and 15 of the Allegation

194. The Tribunal noted that that which is alleged in paragraphs 2, 3, 4 and 5, in relation to Patient A, mirrored that which is alleged at paragraphs 12, 13, 14 and 15,

in respect of Patient B. Accordingly, for the reasons which it has already set out above, it found:

12. The Consent Forms provided to Patient C stated that:
  - a. the higher limit of normal testosterone range was 40 nmol/L;  
**Found proved**
  - b. untreated hypogonadism can increase risk of:
    - i. heart disease; **Found proved**
    - ii. Alzheimer's disease; **Found proved**
    - iii. premature death; **Found proved**
  - c. the treatment provided was TRT. **Found proved**
13. You knew that the information in the Consent Forms was untrue as:
  - a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **Found proved**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **Found not proved**
    - ii. Alzheimer's disease; **Found not proved**
    - iii. Premature death; **Found not proved**
  - c. the treatment provided increased testosterone above normal limits and was not TRT. **Found not proved**
14. Your conduct as set out at paragraph 12 was dishonest by reason of paragraph 13. **Found proved (in relation to 12a by reason of 13a)**
15. You did not obtain informed consent from Patient C for treatment you provided in that:
  - a. you failed to counter-sign the Consent Forms;  
**Found not proved**
  - b. the Consent Forms contained statements which were untrue.  
**Found proved**

#### **Patient D**

195. In respect of this patient, the Tribunal did not have any direct evidence from Patient D. the Tribunal had Patient D's BMH medical records, a Patient Summary and a patient contact note from MHC relating to Patient D.

Paragraph 16a of the Allegation

16. Between September 2017 and September 2018, you failed to provide good clinical care to Patient D in that you:

- a. did not hold a consultation with Patient D; **Found proved**

196. For the same reasons as set out in relation to Patient A at paragraph 1a, the Tribunal found paragraph 16a of the Allegation proved.

Paragraphs 16bi, ii and iii of the Allegation

16. Between September 2017 and September 2018, you failed to provide good clinical care to Patient D in that you:

- b. did not elicit an adequate medical history from Patient D, in that you did not elicit details of:
  - i. sexual symptoms; **Found proved**
  - ii. non-sexual symptoms; **Found proved**
  - iii. answers to general health questions concerning the complaint; **Found proved**

197. The Tribunal noted that there was no evidence of any record of Dr Webberley 'drilling down' to elicit an adequate medical history from Patient D, and the history was limited to that which was recorded in the patient questionnaire. For this reason, and those set out in relation to Patient A at paragraph 1bi, ii and iii, the Tribunal found paragraphs 16bi, ii and iii of the Allegation proved.

Paragraph 16c of the Allegation

16. Between September 2017 and September 2018, you failed to provide good clinical care to Patient D in that you:

- c. did not perform any physical or mental health examination; **Found not proved**

198. For the same reasons as set out in relation to Patient A at paragraph 1c, the Tribunal found paragraph 16c of the Allegation not proved.

Paragraphs 16di and ii and 16ei and ii of the Allegation

16. Between September 2017 and September 2018, you failed to provide good clinical care to Patient D in that you:
- d. inappropriately diagnosed Patient D with hypogonadism in that:
    - i. the diagnosis was not supported by laboratory results;  
**Found proved**
    - ii. you failed to consider any alternative diagnosis;  
**Found proved**
  - e. prescribed testosterone, hCG, anastrozole and mesterolone which was:
    - i. not clinically indicated; **Found proved**
    - ii. unsafe; **Found proved**

199. The circumstances of the diagnosis of hypogonadism in the present case was notably different from those in respect of other patients considered by the Tribunal. The initial blood tests performed prior to prescription showed low normal testosterone, very low free testosterone, and low levels of LH. These results were capable of indicating hypogonadotropic hypogonadism. Indeed, Dr Quinton opined that the results should have triggered a full pituitary hormone evaluation and pituitary MRI scan. Dr Webberley did not initiate either of these further investigations, neither was there any evidence that he gave any consideration to the same. Dr Quinton, whilst recognising that the results might have indicated hypogonadotropic hypogonadism, stated they could also be consistent with recent use of testosterone or anabolic steroids. Indeed, it was of note that Patient D had indicated to BMH, at the outset, that he wanted a prescription for testosterone, hCG and anabolic steroids.

200. Rather than performing a pituitary 'work up' to confirm the diagnosis of hypogonadism as he should have done, Dr Webberley prescribed a treatment regime that Patient D had requested, and which was unnecessary even for a man with a verified diagnosis of hypogonadism. A treatment regime, which Dr Quinton described as, and which the Tribunal accepted, was a popular combination of drugs for body builders but which was entirely lacking evidence of safety and efficacy in the treatment of male hypogonadism.

201. Accordingly, the Tribunal found paragraphs 16di and ii, and 16ei and ii of the Allegation proved.

#### Paragraphs 16fi and ii of the Allegation

16. Between September 2017 and September 2018, you failed to provide good clinical care to Patient D in that you:

- f. did not conduct tests adequately in that you failed to:
  - i. specify the conditions under which blood should be drawn; **Found not proved**
  - ii. check Patient D's full blood count for haematocrit until five months after starting treatment; **Found proved**

202. In relation to paragraph 6fi, the Tribunal was unable to infer from the available evidence and, on the balance of probabilities, that Dr Webberley or someone else on his behalf, had not told Patient D the conditions under which blood should be drawn.

203. Therefore, the Tribunal found this paragraph of the Allegation not proved.

204. In relation to paragraph 16fii, the laboratory tests results obtained between 4 September 2017 and February 2018 did not include full blood counts for haematocrit. These tests should have been performed given that Dr Webberley had prescribed testosterone in September 2017, and he should have been aware of the risk of erythrocytosis and therefore he should have been obtaining full blood count tests for monitoring purposes.

205. Accordingly, the Tribunal found paragraph 16fii of the Allegation proved.

#### Paragraphs 16gi, ii, iii, iv and 16h of the Allegation

- 16. Between September 2017 and September 2018, you failed to provide good clinical care to Patient D in that you:
  - g. did not accurately interpret test results on 4 September 2017 when they showed evidence of:
    - i. anabolic steroid abuse; **Found not proved**
    - ii. clinically significant pituitary mass lesion; **Found not proved**
    - iii. acute kidney injury; **Found not proved**
    - iv. intake of undeclared creatine supplements; **Found not proved**
  - h. did not accurately interpret repeat test results on 15 February 2018 when they showed evidence of that as set out at paragraph 16.g above; **Found not proved**

206. In relation to paragraphs 16gi and ii, Dr Quinton's evidence was not that the test results of 4 September 2017 showed evidence of anabolic steroid abuse or

clinically significant pituitary mass lesion. His evidence was that the results indicated 'the worrying possibility' of either of these two conditions.

207. As to paragraphs 16giii and iv, the test results as of 4 September 2017 did not show even the possibility of acute kidney injury or the indication of creatine supplements. These possibilities only became apparent in subsequent tests in February 2018.

208. As to paragraph 16h, again, it was not Dr Quinton's opinion that the test results of 15 February 2018 showed evidence of any of the four conditions. Rather, he stated the test results raised the possibility of some or other of these conditions being present. The Tribunal therefore found paragraphs 16gi, ii, iii and iv, and 16h not proved.

#### Paragraph 16i of the Allegation

16. Between September 2017 and September 2018, you failed to provide good clinical care to Patient D in that you:
  - i. did not reduce Patient D's medication following receipt of test results as set out at paragraphs 16.g – h above;  
**Found not proved**

209. The test results which are the subject of this allegation were those conducted 4 September 2017 and 15 February 2018. Neither of these test results showed testosterone levels higher than the normal reference range. Accordingly, these results did not of themselves indicate that a reduction in medication (testosterone) was required. The Tribunal noted that it was the test results of 19 December 2017 (which was not the subject of the allegation in paragraph 16i) that indicated the possibility of excessive testosterone treatment, and which may have indicated, consistent with Dr Quinton's evidence, a need to reduce testosterone dosage at this time. However, this was not the allegation, and the Tribunal did not consider it appropriate or fair to consider amendment at this late stage, given that Dr Webberley was neither present, nor represented. Therefore, in the Tribunal's view an amendment could not be made without the risk of injustice.

210. Accordingly, the Tribunal found paragraph 16i of the Allegation not proved.

#### Paragraphs 16j and ki and ii of the Allegation

16. Between September 2017 and September 2018, you failed to provide good clinical care to Patient D in that you:
  - j. did not adequately communicate with Patient D in that you delegated communications to non-medically trained members of staff when it was inappropriate to do so; **Found not proved**
  - k. did not provide adequate follow up care in that you:

- i. failed to arrange a follow-up consultation with Patient D after treatment had commenced; **Found not proved**
- ii. relied upon email communication between Patient D and non-clinical facilitators. **Found not proved**

211. In relation to Patient D, the factual evidence was confined to the medical records of BMH and a patient summary from MHC. There was no evidence from Patient D, and it was evident to the Tribunal that the record from BMH was incomplete to the extent that the Tribunal was unable to form a view as to the adequacy of Dr Webberley's communication with Patient D, or whether any delegation of such communication to members of staff was inappropriate. Further, for the same reasons, the Tribunal was unable to form a conclusion as to the adequacy or otherwise of the follow-up care. Although, it noted that the records, such as they were, demonstrated significant contact with non-medically trained staff as opposed to Dr Webberley himself.

212. Accordingly, the Tribunal found paragraphs 16j and 16ki and ii of the Allegation not proved.

Paragraphs 17, 18, 19 and 20 of the Allegation

213. The Tribunal noted that that which is alleged in paragraphs 2, 3, 4 and 5, in relation to Patient A, mirrored that which is alleged at paragraphs 17, 18, 19 and 20, in respect of Patient D (with the exception of 17d and 18d). Accordingly, for the reasons which it has already set out above, it found:

- 17. The Consent Forms provided to Patient D stated that:
  - a. the higher limit of normal testosterone range was 40 nmol/L; **Found proved**
  - b. untreated hypogonadism can increase risk of:
    - i. heart disease; **Found proved**
    - ii. Alzheimer's disease; **Found proved**
    - iii. premature death; **Found proved**
  - c. the treatment provided was TRT; **Found proved**
- 18. You knew that the information in the Consent Forms was untrue as:
  - a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **Found proved**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:

- i. heart disease; **Found not proved**
    - ii. Alzheimer’s disease; **Found not proved**
    - iii. premature death; **Found not proved**
  - c. the treatment provided increased testosterone above normal limits and was not TRT; **Found not proved**
19. Your conduct as set out at paragraph 17 was dishonest by reason of paragraph 18. **Found proved (in relation to 17a by reason of 18a)**
20. You did not obtain informed consent from Patient D for treatment you provided in that:
- a. you failed to counter-sign the Consent Forms; **Found not proved**
  - b. the Consent Forms contained statements which were untrue. **Found proved**

Paragraph 17d of the Allegation

17. The Consent Forms provided to Patient D stated that:
- d. Patient D will not take ‘any type of anabolic steroid’. **Found proved**

214. With regard to paragraph 17d, the statement appeared on the face of the consent form and the Tribunal found this paragraph proved.

Paragraph 18d of the Allegation

18. You knew that the information in the Consent Forms was untrue as:
- d. you prescribed or arranged to be prescribed anabolic steroids to Patient D. **Found not proved**

215. Although there was a statement contained in the consent form in the terms found proved in relation to paragraph 17d the full statement said:

*“I will not take any type of anabolic steroids testosterone gels ... or any additional testosterone supplementation **not provided by the doctor treating me through Balance My Hormones ltd**” [Tribunal’s emphasis].*

216. The basis of this allegation was that Dr Webberley had obtained consent from Patient D upon an undertaking that Patient D would not take anabolic steroids in circumstances where Dr Webberley intended to prescribe the same to Patient D

and that he would take them. Hence, it was alleged that the statement in the consent form was untrue. However, as set out above the undertaking was in fact that Patient D would not take anabolic steroids otherwise than that provided by the treating doctor at BMH Ltd, i.e. Dr Webberley.

217. Accordingly, the Tribunal found paragraph 18d, insofar as it related to 17d, not proved.

### **Patient E**

218. In respect of this patient, the Tribunal did not have direct evidence from Patient E. It had medical records provided by BMH and some patient contact notes with MHC relating to Patient E.

### **Paragraph 21a of the Allegation**

21. Between September 2017 and September 2018, you failed to provide good clinical care to Patient E in that you:

a. did not hold a consultation with Patient E; **Found proved**

219. The Tribunal having reviewed the BMH Medical records concluded that there had been no consultation held during the relevant time. Accordingly, for reasons previously given, in respect of Patient A at paragraph 1a, the Tribunal found paragraph 21a of the Allegation proved.

### **Paragraphs 21bi and ii of the Allegation**

21. Between September 2017 and September 2018, you failed to provide good clinical care to Patient E in that you:

b. did not elicit an adequate medical history from Patient E, in that you did not elicit details of:

i. underlying causes of Patient E's abnormal ALT level;  
**Found proved**

ii. Patient E's previous use of anabolic steroids;  
**Found proved**

220. Following a blood test in September 2017, abnormal ALT levels were shown and which, in Dr Quinton's opinion, were noteworthy as being potentially relevant to fatty liver, alcohol or hepatitis and, when Patient E subsequently consulted MHC, he disclosed previous use of anabolic steroids. The only medical history apparently taken from Patient E was that contained in a patient intake form and a summary taken in a patient summary form (dated 12 October 2017). Neither of these documents referred to these potentially significant matters. Accordingly, the Tribunal determined that Dr Webberley should have elicited this information and had not done so.

221. Accordingly, the Tribunal found paragraphs 21bi and ii of the Allegation proved.

Paragraph 21c of the Allegation

21. Between September 2017 and September 2018, you failed to provide good clinical care to Patient E in that you:

- c. did not perform any physical or mental health examination;  
**Found not proved**

222. For the same reason given in relation to Patient A and paragraph 1c, the Tribunal found paragraph 21c of the Allegation not proved.

Paragraphs 21di and ii of the Allegation

21. Between September 2017 and September 2018, you failed to provide good clinical care to Patient E in that you:

- d. inappropriately diagnosed Patient E with hypogonadism in that:
  - i. the diagnosis was contrary to laboratory results which showed normal gonadal function; **Found proved**
  - ii. you failed to consider any alternative diagnosis;  
**Found proved**

223. The evidence demonstrated that Patient E had never had a consultation with Dr Webberley and a comprehensive medical history nor had a comprehensive medical history taken from him. The only material that Dr Webberley had to make a diagnosis was the patient intake form, a patient summary form, and the results of three blood tests. All the blood tests were within the normal range for testosterone. Two of the tests showed 13.6 nmol/L, one test showed 21.6 nmol/L. The Tribunal noted that the latter test was dismissed as 'an anomaly' by Dr Webberley, despite it being within acceptable normal range. In these circumstances, the Tribunal found paragraph 21di proved. Further, by treating Patient E's reported symptoms as hypogonadism, the Tribunal determined that Dr Webberley necessarily failed to consider alternative diagnosis, for example androgen seeking behaviour.

224. Accordingly, the Tribunal found paragraphs 21di and ii of the Allegation proved.

Paragraphs 21ei and ii of the Allegation

21. Between September 2017 and September 2018, you failed to provide good clinical care to Patient E in that you:

- e. prescribed testosterone, hCG and mesterolone which was:
  - i. not clinically indicated; **Found proved**
  - ii. unsafe; **Found proved**

225. The Tribunal accepted Dr Quinton's evidence that, even if Patient E had been correctly diagnosed with hypogonadism, the treatment regime as reflected in the prescription comprising testosterone (at double the typical physiological dose) with mesterolone and anastrozole, whilst typical of a 'body builders' cocktail', would not be clinically indicated and would be unsafe.

226. However, the Tribunal noted that the stem of the allegation referred to a prescription of hCG and not anastrozole. The Tribunal therefore found paragraph 21ei and ii proved in respect of testosterone and mesterolone, but not hCG.

#### Paragraph 21f of the Allegation

- 21. Between September 2017 and September 2018, you failed to provide good clinical care to Patient E in that you:
  - f. did not conduct tests adequately; **Found not proved**

227. Dr Quinton criticised Dr Webberley in two respects with regard to this allegation. Firstly, that Dr Webberley had failed to order full blood count tests, and secondly, that he should have ordered baseline LH and FSH levels. In relation to the first criticism, Dr Quinton was in error as the blood test within the BMH records demonstrated that a full blood count test was undertaken on 16 September 2017. This test showed normal haemoglobin and haematocrit. As to the second criticism, and as the Tribunal concluded in relation to Patient B, the Tribunal did not consider that Dr Webberley could be criticised for not initially obtaining an LH and FSH level, and such a test may not have subsequently been necessary in the light of normal levels of testosterone.

228. Accordingly, the Tribunal found paragraph 21f of the Allegation not proved.

#### Paragraphs 21g and h of the Allegation

- 21. Between September 2017 and September 2018, you failed to provide good clinical care to Patient E in that you:
  - g. did not review and adjust Patient E's treatment plan following concerns raised regarding symptoms of over-treatment of testosterone; **Found not proved**
  - h. did not adequately communicate with Patient E in that you delegated communications to non-medically trained members of staff when it was inappropriate to do so; **Found not proved**

229. With regard to paragraph 21g, the BMH records indicate that it was in November 2017 that concerns were raised regarding *symptoms* of over treatment of testosterone. This was an email correspondence between Patient E and Dr Webberley, as a result of which, Dr Webberley adjusted Patient E's treatment plan in relation to the prescription of anastrozole and Patient E subsequently reported an improvement in his symptoms.

230. Accordingly, the Tribunal found paragraph 21g of the Allegation not proved.

231. The medical records demonstrated that much of Patient E's communication was with non-medically trained members of staff at BMH. However, there was also email correspondence between Patient E and Dr Webberley directly. Not only with regard to Patient E developing symptoms associated with gynaecomastia in around 2017, but also as to the possibility of Patient E having hypothyroidism in July 2018. Furthermore, the Tribunal noted that non-medically trained members of staff at BMH gave Patient E the opportunity to speak directly with Dr Webberley, but Patient E expressed the preference of communicating with him by email, which he continued to do.

232. Accordingly, the Tribunal found paragraph 21h of the Allegation not proved.

#### Paragraph 21i of the Allegation

21. Between September 2017 and September 2018, you failed to provide good clinical care to Patient E in that you:

- i. did not maintain an adequate record throughout the period of treatment of Patient E. **Found proved**

233. The Tribunal found that the medical record was inadequate, in particular, having regard to Patient E's medical history.

234. Accordingly, the Tribunal found paragraph 21i of the Allegation proved.

#### Paragraphs 22, 23, 24 and 25 of the Allegation

235. The Tribunal noted that that which is alleged in paragraphs 2, 3, 4 and 5, in relation to Patient A, mirrored that which is alleged at paragraphs 22, 23, 24 and 25 (with the exception of 22d and 23d). Additionally, that which is alleged at paragraphs 17d and 18d in relation to Patient D, mirrored that which is alleged at paragraphs 22d and 23d. Accordingly, for the reasons which it has already set out above, it found:

22. The Consent Forms provided to Patient E stated that:

- a. the higher limit of normal testosterone range was 40 nmol/L;  
**Found proved**
- b. untreated hypogonadism can increase the risk of:

- i. heart disease; **Found proved**
    - ii. Alzheimer's disease; **Found proved**
    - iii. premature death; **Found proved**
  - c. the treatment provided was TRT; **Found proved**
  - d. Patient E will not take 'any type of anabolic steroid'.  
**Found proved**
23. You knew that the information in the Consent Forms was untrue as:
- a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **Found proved**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **Found not proved**
    - ii. Alzheimer's disease; **Found not proved**
    - iii. premature death; **Found not proved**
  - c. the treatment to be provided would increase testosterone above normal limits and was not TRT; **Found not proved**
  - d. you prescribed, or arranged to be prescribed, anabolic steroids to Patient E. **Found not proved**
24. Your conduct as set out at paragraph 22 was dishonest by reason of paragraph 23. **Found proved (in relation to 22a by reason of 23a)**
25. You did not obtain informed consent from Patient E for treatment you provided in that:
- a. you failed to counter-sign the Consent Forms;  
**Found not proved**
  - b. the Consent Forms contained statements which were untrue.  
**Found proved**

### **Patient F**

236. In respect of this patient, the Tribunal had evidence from Patient F together with Patient F's patient contact note from MHC. The Tribunal had no BMH medical notes.

#### Paragraph 26a of the Allegation

26. Between October 2017 and December 2018, you failed to provide good clinical care to Patient F in that you:

- a. did not hold a consultation with Patient F; **Found proved**

237. For the same reasons in reasons given in relation to Patient A at paragraph 1a, and other patients, the Tribunal determined that there should have been a consultation and the Tribunal accepted F's evidence that one was not held.

238. Accordingly, the Tribunal found paragraph 26a of the Allegation proved.

#### Paragraphs 26bi, ii and iii of the Allegation

26. Between October 2017 and December 2018, you failed to provide good clinical care to Patient F in that you:

- b. did not elicit an adequate medical history from Patient F, in that you did not elicit details of:
  - i. sexual symptoms; **Found proved**
  - ii. non-sexual symptoms; **Found proved**
  - iii. answers to general health questions concerning the presenting complaint; **Found proved**

239. Consistent with the conclusion the Tribunal has reached in relation to other androgen patients, the Tribunal considered that Dr Webberley should have obtained a medical history from Patient F prior to diagnosis and prescription.

240. Patient F did not, at any stage during his treatment by BMH, see or speak to Dr Webberley, and no medical history appeared to have been given to anyone at BMH beyond the fact that Patient F completed, what he described as, 'an online test', which the Tribunal inferred was the online patient questionnaire. Although the Tribunal did not have a copy of this completed questionnaire, it inferred that reliance upon such a questionnaire alone without investigating or 'drilling down', into answers given, as Dr Quinton described would have meant that an adequate medical history could not have been elicited from Patient F, as the Tribunal had already observed, should have happened prior to any diagnosis and prescription.

241. For these reasons, and those given in relation to Patient A at paragraph 1a, the Tribunal found paragraphs 26bi, ii and iii of the Allegation proved.

#### Paragraph 26c of the Allegation

26. Between October 2017 and December 2018, you failed to provide good clinical care to Patient F in that you:
- c. did not perform any physical or mental health examination of Patient F; **Found not proved**

242. For the same reasons as set out in relation to Patient A at paragraph 1c of the Allegation, the Tribunal found paragraph 26c not proved.

Paragraphs 26di1 and 2 of the Allegation

26. Between October 2017 and December 2018, you failed to provide good clinical care to Patient F in that you:
- d. prescribed testosterone:
    - i. which was inappropriate in that it was:
      - 1. not clinically indicated; **Found proved**
      - 2. double the typical physiological replacement dose; **Found proved**

243. In relation to Patient F, two blood test were performed prior to the prescription of testosterone. The results of these two tests were not before the Tribunal and were not therefore considered by Dr Quinton, although the Tribunal noted that Patient F reported that his testosterone levels had been shown to be 'low'. Nevertheless, Dr Quinton opined that the dose / frequency of the testosterone Dr Webberley went onto prescribe, was almost double that which was appropriate for a man with hypogonadism. Accordingly, the Tribunal found that the prescription was inappropriate in that it could not have been clinically indicated as it was double the typical physiological replacement dose.

244. Accordingly, the Tribunal found paragraphs 26di1 and 2 of the Allegation proved.

Paragraph 26e of the Allegation

26. Between October 2017 and December 2018, you failed to provide good clinical care to Patient F in that you:
- e. did not conduct / arrange all necessary tests before prescribing medication to Patient F; **Found not proved**

245. As the Tribunal did not have the laboratory test results for the blood tests conducted before prescribing to Patient F, it was therefore unable to determine precisely what blood tests were performed. It could not therefore be satisfied, on the balance of probabilities, that Dr Webberley had not included all necessary tests.

246. Accordingly, the Tribunal found paragraph 26e of the Allegation not proved.

Paragraph 26f of the Allegation

26. Between October 2017 and December 2018, you failed to provide good clinical care to Patient F in that you:

- f. did not adequately explain to Patient F how to safely administer the prescribed medication; **Found proved**

247. Patient F's evidence was that he had not received any instructions [from anyone] on how to administer his medication and he stated that 'it didn't feel right as there was a real lack of medical based information'. The Tribunal accepted this evidence.

248. Accordingly, the Tribunal found paragraph 26f of the Allegation proved.

Paragraphs 26g, h and i of the Allegation

26. Between October 2017 and December 2018, you failed to provide good clinical care to Patient F in that you:

- g. did not review Patient F's treatment plan; **Found proved**
- h. did not adequately communicate with Patient F; **Found proved**
- i. did not provide adequate follow up care; **Found proved**

249. The Tribunal did not have sight of any medical records from BMH in relation to Patient F. However, Patient F's evidence was that he emailed Dr Webberley as he had a number of questions concerning his treatment and, in particular, an enquiry concerning a recent review blood test that showed his testosterone to be over the upper end of the (normal) scale. He received no response from Dr Webberley and sent a further email, this time copied into one of the 'facilitators' (one of the non-medically trained members of staff). In response, Patient F received a telephone call from one of the facilitators who did answer his questions. At this stage Patient F was concerned at what appeared to be (BMH's) 'cavalier attitude' towards medicine and so he went to an alternative medical provider (MHC).

250. The Tribunal considered that, at the very least, and accepting Dr Quinton's evidence, Dr Webberley having been contacted by Patient F in relation to abnormal blood test results, should have reviewed the treatment plan, should have communicated with Patient F and provided follow up care, which he did not do.

251. Accordingly, the Tribunal found paragraphs 26g, h and i of the Allegation proved.

Paragraphs 26j and k of the Allegation

26. Between October 2017 and December 2018, you failed to provide good clinical care to Patient F in that you:
- j. did not obtain informed consent from Patient F in that you did not explain the risks and benefits of proposed treatment;  
**Found not proved**
  - k. did not maintain adequate medical records throughout the period of treatment of Patient F. **Found not proved**

252. Patient F's witness statement did not deal specifically with the issue of whether he had received any information in relation to risks and benefits prior to consenting to treatment and, as no medical records from BMH were available in relation to this patient, the Tribunal found paragraphs 26j and k of the Allegation not proved.

### **Patient G**

253. In respect of this patient, the Tribunal had Patient G's BMH medical notes and contact notes from MHC relating to Patient G. It had no direct evidence from Patient G.

### **Paragraph 27a of the Allegation**

27. Between 6 December 2017 and 23 April 2018, you failed to provide good clinical care to Patient G in that you:
- a. did not hold a consultation with Patient G; **Found proved**

254. For the reasons previously given in respect of other patients, the Tribunal considered that Dr Webberley should have had a consultation with Patient G.

255. In this case, the BMH's medical record for the patient appeared complete insofar as it appeared to cover the period during which Patient G was a patient of BMH. The Tribunal determined that there was nothing in this medical record to suggest that Dr Webberley had directly spoken to Patient G, much less seen him face-to-face or had any consultation with him. Accordingly, the Tribunal determined paragraph 27a of the Allegation proved.

### **Paragraphs 27bi, ii, iii and iv of the Allegation**

27. Between 6 December 2017 and 23 April 2018, you failed to provide good clinical care to Patient G in that you:
- b. did not elicit an adequate medical history from Patient G, in that you did not elicit details of:
    - i. sexual symptoms; **Found proved**

- ii. non-sexual symptoms; **Found proved**
- iii. answers to general health questions concerning the presenting complaint; **Found proved**
- iv. Patient G's alcohol intake; **Found not proved**

256. As the Tribunal has previously observed in relation to other patients, Dr Webberley should have obtained an adequate medical history. The only medical history apparently elicited from Patient G, was the information provided by Patient G via the patient questionnaire submitted online to BMH. For this reason, and for the reasons previously given in relation to paragraph 1a, the Tribunal found paragraphs 27bi, ii and iii proved.

257. In relation to 27biv, the Tribunal found this not proved because Patient G had, in the Tribunal's judgement, given sufficient detail as to his alcohol intake, namely, he had said '8 beers a week'. The Tribunal did not consider that Dr Webberley could be criticised for failing to elicit further details of Patient G's alcohol intake. Furthermore, the Tribunal did not consider that the fact that Patient G was reporting to a different doctor, in September 2018, alcohol intake of 10 units per night was relevant.

258. Accordingly, the Tribunal found paragraph 27biv of the Allegation not proved.

#### Paragraph 27c of the Allegation

27. Between 6 December 2017 and 23 April 2018, you failed to provide good clinical care to Patient G in that you:

- c. did not perform any physical or mental health examination;  
**Found proved**

259. The Tribunal considered that, whereas Patient G's answers contained within the patient questionnaire would not necessarily have triggered a mental health examination, the medical records for the period covering Patient G's treatment with BMH demonstrated that Patient G was suffering potentially serious, mental health issues. For example, in March 2018, the record demonstrated "*anxiety+++*", this was entered by Dr Webberley, and in April 2018, "*feeling really unwell, very anxious... so anxious at one point almost felt suicidal. Doctor informed.*"

The latter entry was entered by a non-medically trained member of staff. In the Tribunal's judgement this reported state of affairs should have prompted Dr Webberley to have undertaken a mental health examination or refer Patient G for the same.

260. Accordingly, the Tribunal found paragraph 27c of the Allegation proved.

#### Paragraphs 27di and ii of the Allegation

27. Between 6 December 2017 and 23 April 2018, you failed to provide good clinical care to Patient G in that you:
- d. inappropriately diagnosed Patient G with hypogonadism in that:
    - i. the diagnosis was not supported by laboratory results;  
**Found proved**
    - ii. you failed to consider any alternative diagnosis;  
**Found proved**

261. The Tribunal accepted the opinion of Dr Quinton that Patient G's clinical presentation strongly suggested a psychological/mental health basis for his symptoms rather than hypogonadism. Furthermore, laboratory tests performed on 18 September 2017 and 16 December 2017 showed normal levels of testosterone and therefore did not support a diagnosis of hypogonadism.

262. Accordingly, the Tribunal found paragraphs 27di and ii of the Allegation proved.

Paragraphs 27ei, ii and iii of the Allegation

27. Between 6 December 2017 and 23 April 2018, you failed to provide good clinical care to Patient G in that you:
- e. prescribed unlicensed testosterone cream and anastrozole which was:
    - i. not clinically indicated; **Found proved**
    - ii. unsafe; **Found proved**
    - iii. not recognised as therapeutic practice in medicine;  
**Found proved**

263. The Tribunal determined that the prescription of testosterone was not clinically indicated, given that Patient G did not have hypogonadism. Further, the Tribunal accepted the evidence of Dr Quinton that even had testosterone treatment been indicated, it was not appropriate to prescribe an unlicensed product in the absence of clinical justification when there were at least three alternative licensed products available in the United Kingdom.

264. The Tribunal also accepted Dr Quinton's evidence that anastrozole had no legitimate application in the field of hypogonadism (except in limited circumstances, namely the treatment of androgen induced hypogonadism as part of a tapering dose therapy). Accordingly, the Tribunal found paragraphs 27ei, ii and ii of the Allegation proved.

#### Paragraph 27f of the Allegation

27. Between 6 December 2017 and 23 April 2018, you failed to provide good clinical care to Patient G in that you:

- f. did not conduct tests adequately in that you failed to check Patient G's full blood count; **Found proved**

265. The Tribunal found this allegation proved. The laboratory test results within BMH's patient record obtained both before and after prescription did not include full blood count tests (December 2017, March 2018 x2 and April 2018), which they should have done, particularly once testosterone had been prescribed.

266. Accordingly, the Tribunal found paragraph 27f of the Allegation proved.

#### Paragraph 27g of the Allegation

27. Between 6 December 2017 and 23 April 2018, you failed to provide good clinical care to Patient G in that you:

- g. did not identify that repeat blood tests were contrary to your diagnosis of hypogonadism; **Found proved**

267. The Tribunal determined that Dr Webberley, obtained the results of two separate blood tests both received during December 2017, the results of which were both contrary to a diagnosis of hypogonadism. Nevertheless, in January 2018, Dr Webberley again prescribed testosterone cream for the treatment of hypogonadism.

268. Accordingly, the Tribunal found paragraph 27g of the Allegation proved.

#### Paragraphs 27h and 27i(i) and (ii) of the Allegation

27. Between 6 December 2017 and 23 April 2018, you failed to provide good clinical care to Patient G in that you:

- h. did not adequately communicate with Patient G; **Found proved**
- i. did not provide adequate follow up care in that you:
  - i. failed to arrange a follow-up consultation with Patient G after treatment had commenced; **Found proved**
  - ii. delegated communications with Patient G to non-medically trained members of staff. **Found proved**

269. The Tribunal found these allegations proved. The Tribunal acknowledged that BMH records showed some limited email communication as between Dr Webberley and Patient G. However, in the main, it appeared that Patient G was communicating with non-medically trained members of staff. In particular, the Tribunal noted that on 12 March 2018 a complaint by Patient G was recorded in the following terms:

*“contacted doctor with urgent symptoms via direct email and didn’t get a response at all “does Dr Webberley really exist”.*

270. On 13 March 2018, the following day, Dr Webberley responded to a member of BMH staff as follows:

*“emailed me, anxiety +++... just for the record I went through all this with him in January too... so the doctor does exist”.*

271. The Tribunal determined that given Dr Webberley had been made aware of his patients’ distress, his response was inadequate both in terms of communication and providing adequate follow up care.

272. Accordingly, the Tribunal found paragraphs 27h and 27hi(i) and (ii) of the Allegation proved.

#### Paragraph 28a of the Allegation

273. The Tribunal noted that that which is alleged in paragraphs 2, 3, 4 and 5, in relation to Patient A, mirrored that which is alleged at paragraphs 28, 29, 30 and 31, in respect of Patient G. Accordingly, for the reasons which it has already set out above, it found:

28. The Consent Forms provided to Patient G stated that:

- a. the higher limit of normal testosterone range was 40 nmol/L;  
**Found proved**
- b. untreated hypogonadism can increase the risk of:
  - i. heart disease; **Found proved**
  - ii. Alzheimer’s disease; **Found proved**
  - iii. premature death; **Found proved**
- c. the treatment provided was TRT. **Found proved**

29. You knew that the information in the Consent Form was untrue as:

- a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **Found proved**

- b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **Found not proved**
    - ii. Alzheimer’s disease; **Found not proved**
    - iii. premature death; **Found not proved**
  - c. the treatment to be provided would increase testosterone above normal limits and was not TRT. **Found not proved**
30. Your conduct as set out at paragraph 28 was dishonest by reason of paragraph 29. **Found proved (in relation 28a by reason of 29a)**
31. You did not obtain informed consent from Patient G for treatment you provided in that:
- a. you failed to counter-sign the Consent Forms;  
**Found not proved**
  - b. the Consent Forms contained statements which were untrue.  
**Found proved**

### **Patient H**

274. In respect of this patient, the Tribunal had Patient H’s BMH medical notes together with contact notes from MHC relating to Patient H. It did not have any direct evidence from Patient H.

### **Paragraphs 32ai1, 2 and 3 of the Allegation**

32. Between 28 December 2017 and 18 May 2018, you failed to provide good clinical care to Patient H in that you:
- a. consulted with Patient H on 6 January 2018 and failed to:
    - i. elicit an adequate medical history in that you did not:
      - 1. elicit details of sexual symptoms:  
**Found not proved**
      - 2. elicit details of non-sexual symptoms;  
**Found not proved**
      - 3. ask general health questions concerning the presenting complaint; **Found not proved**

275. The Tribunal considered that there was a record within the medical notes that a consultation had occurred on 6 January 2018, though the note appeared to have been entered into the record on 6 February 2018. It considered that the date entry of 6 January 2018 could be an error. In any event, the note records some medical history was taken including reference to some sexual symptoms, non-sexual symptoms and general health questions. Although Dr Quinton considered the detail to be inadequate in terms of a medical history, the Tribunal was unable to determine whether any such inadequacy was as a result of the detail not being elicited or simply not being properly recorded.

276. Accordingly, the Tribunal found paragraphs 32ai1, 2 and 3 of the Allegation not proved.

#### Paragraph 32b of the Allegation

32. Between 28 December 2017 and 18 May 2018, you failed to provide good clinical care to Patient H in that you:

- b. did not perform any physical or mental health examination;  
**Found not proved**

277. The Tribunal did not consider that the evidence demonstrated any particular reason for a physical and/or mental health examination with Patient H given the fact that there had been a consultation and that Dr Webberley may have satisfied himself that an examination was unnecessary.

278. Accordingly, the Tribunal found paragraph 32b of the Allegation not proved.

#### Paragraphs 32ci and ii of the Allegation

32. Between 28 December 2017 and 18 May 2018, you failed to provide good clinical care to Patient H in that you:

- c. inappropriately diagnosed Patient H with hypogonadism in that:
  - i. the diagnosis was not supported by laboratory results;  
**Found proved**
  - ii. you failed to consider any alternative diagnosis;  
**Found proved**

279. The Tribunal noted that Dr Webberley, by the time of his diagnosis and prescription for the treatment of hypogonadism, had available to him the results of three separate blood tests, all of which showed testosterone levels within a normal range. The Tribunal accepted the opinion evidence of Dr Quinton that this was against a diagnosis of hypogonadism and the reported symptoms were not definitive to a diagnosis of this condition. Furthermore, the Tribunal noted Dr Webberley's record of his consultation with Patient H in which he stated:

*“he is very symptomatic despite borderline T levels [in Dr Quinton’s opinion they were not] and I think on balance it is justifiable to give him the benefit of the doubt with TRT”.*

280. In these circumstances, the Tribunal determined that the diagnosis was inappropriate, was not supported by blood test results, and failed to consider other explanations for Patient H’s reported symptoms.

281. Accordingly, the Tribunal found paragraphs 32ci and ii of the Allegation proved.

#### Paragraph 32di of the Allegation

32. Between 28 December 2017 and 18 May 2018, you failed to provide good clinical care to Patient H in that you:

- d. prescribed testosterone propionate, hCG and anastrozole:
  - i. despite the fact that Patient H had expressly stated he did not want to compromise his fertility;  
**Found proved**

282. The Tribunal accepted the expert opinion evidence of Dr Quinton that the administration of exogenous testosterone suppresses the production of endogenous testosterone and, as such, he stated ‘a desire to maintain fertility is an absolute contra indication to testosterone replacement therapy’. It was Dr Quinton’s opinion this was so, even despite the combination with hCG which can, in some circumstances, be prescribed in an attempt to restore fertility. However, in this instance, Dr Quinton’s opinion was that the dose prescribed was markedly sub-therapeutic for this purpose. Patient H’s medical notes recorded that Patient H had expressly stated that he wished to maintain or restore his fertility.

283. Accordingly, the Tribunal found paragraph 32di of the Allegation proved.

#### Paragraph 32dii1, 2 and 3 of the Allegation

32. Between 28 December 2017 and 18 May 2018, you failed to provide good clinical care to Patient H in that you:

- d. prescribed testosterone propionate, hCG and anastrozole:
  - ii. which was:
    - 1. not clinically indicated; **Found proved**
    - 2. unsafe; **Found proved**

3. not recognised as therapeutic practice in medicine; **Found proved**

284. By reason of the fact that there was no proper clinical basis for a diagnosis of hypogonadism, the Tribunal accepted that a prescription of testosterone was not clinically indicated. Furthermore, the treatment regime prescribed was described by Dr Quinton as not just 'TRT' but was a 'full dose stacking regimen', i.e. a regimen more appropriate for someone who was seeking medication for the purposes of 'body building'. The Tribunal accepted Dr Quinton's evidence that the prescription regime was unsafe and not a recognised therapeutic practice in medicine.

285. Accordingly, the Tribunal found paragraphs 32dii1, 2 and 3 of the Allegation proved.

#### Paragraphs 32ei and ii of the Allegation

32. Between 28 December 2017 and 18 May 2018, you failed to provide good clinical care to Patient H in that you:

- e. did not conduct tests adequately in that you failed to:
  - i. specify the conditions under which blood should be drawn; **Found not proved**
  - ii. arrange a repeat check of Patient H's full blood count; **Found proved**

286. The Tribunal was unable to infer from the evidence before it that Dr Webberley, or someone else on his behalf, had not specified to Patient H the conditions under which blood should be drawn.

287. Accordingly, the Tribunal found paragraph 32ei of the Allegation not proved.

288. In relation to paragraph 32eii, BMH's medical records for Patient H showed that full blood count tests were performed prior to Dr Webberley's diagnosis and prescription. However, the monitoring blood tests performed subsequently, in March 2018, did not include a full blood count test. They should have done, by reason of the risk identified by Dr Quinton of androgen induced erythrocytosis consequent upon the prescription of exogenous testosterone and, which in this case, was a high dose.

289. Accordingly, the Tribunal found paragraph 32eii of the Allegation proved.

#### Paragraph 32f of the Allegation

32. Between 28 December 2017 and 18 May 2018, you failed to provide good clinical care to Patient H in that you:

- f. did not identify that subsequent test results evidenced signs of over treatment of testosterone; **Found not proved**

290. The Tribunal accepted that Patient H, who prior to treatment, had levels of testosterone within the normal range, did not therefore require exogenous testosterone and that the high dose prescribed by Dr Webberley was unnecessary and would inevitably increase in testosterone levels in the blood. However, the Tribunal noted that the testosterone levels recorded in March 2018, post prescription, were within the 'high-normal range', which Dr Quinton noted. In these circumstances, the Tribunal considered that the March 2018 blood test (the only blood test in the record after prescription) did not evidence 'signs of over treatment of testosterone' - the testosterone levels were within the normal range.

291. Accordingly, the Tribunal found paragraph 32f of the Allegation not proved.

#### Paragraphs 32g and h of the Allegation

32. Between 28 December 2017 and 18 May 2018, you failed to provide good clinical care to Patient H in that you:

- g. did not adequately communicate with Patient H in that you failed to maintain regular correspondence; **Found proved**
- h. did not provide adequate follow up care in that you failed to arrange a follow-up consultation with Patient H after treatment had commenced. **Found proved**

444. The Tribunal noted that the medical records were incomplete, and it had no direct evidence from Patient H. However, in the patient summary from the treatment provider to whom Patient H went after leaving BMH, records that patient H, despite communicating with BMH and making enquiries as to the success or failure of his treatment, received no follow up from Dr Webberley. The Tribunal was mindful that this was hearsay evidence but nevertheless, given the detail in the note, which was apparently compiled by another medical practitioner, the Tribunal accepted the evidence and concluded it demonstrated inadequate communication and follow up care.

292. Accordingly, the Tribunal found paragraphs 32g and h of the Allegation proved.

#### Paragraphs 33, 34, 35 and 36 of the Allegation

293. The Tribunal noted that that which is alleged in paragraphs 2, 3, 4 and 5, in relation to Patient A, mirrored that which is alleged at paragraphs 33, 34, 35 and 36 10, in respect of Patient H. Accordingly, for the reasons which it has already set out above, it found:

33. The Consent Forms provided to Patient H stated that:

- a. the higher limit of normal testosterone range was 40 nmol/L;  
**Found proved**
  - b. untreated hypogonadism can increase the risk of:
    - i. heart disease; **Found proved**
    - ii. Alzheimer's disease; **Found proved**
    - iii. premature death; **Found proved**
  - c. the treatment provided was TRT. **Found proved**
34. You knew that the information in the Consent Forms was untrue as:
- a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **Found proved**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **Found not proved**
    - ii. Alzheimer's disease; **Found not proved**
    - iii. premature death; **Found not proved**
  - c. the treatment to be provided would increase testosterone above normal limits and was not TRT. **Found not proved**
35. Your conduct as set out at paragraph 33 was dishonest by reason of paragraph 34. **Found proved (in relation on 33a in respect of 34a)**
36. You did not obtain informed consent from Patient H for treatment you provided in that:
- a. you failed to counter-sign the Consent Forms;  
**Found not proved**
  - b. the Consent Forms contained statements which were untrue.  
**Found proved**

### **Patient I**

294. The Tribunal noted that the evidence in relation to the care provided to Patient I was very limited, comprising an obviously incomplete medical record from BMH and a short patient contact note from MHC relating to Patient I.

### **Paragraphs 37ai1, 2 and 3, and 37aii of the Allegation**

37. Between 5 January 2018 and 23 March 2018, you failed to provide good clinical care to Patient I in that you:
- a. consulted with Patient I on ~~31 January 2018~~ 30 January 2018 and failed to:
    - i. elicit an adequate medical history in that you:
      - 1. relied upon details obtained by a non-medically trained member of staff; **Found not proved**
      - 2. failed to elicit details of sexual symptoms; **Found not proved**
      - 3. failed to elicit details of non-sexual symptoms; **Found not proved**
    - ii. ask general health questions concerning the presenting complaint; **Found not proved**

295. The patient record referred to a consultation on 5 January 2018 with Dr Webberley, although it was not entirely clear whether this was in fact a consultation, or a recitation of patient information obtained by a non-medically trained member of staff. However, the record did demonstrate that there was a consultation between Dr Webberley and Patient I on 30 January 2018 (it appeared that this was a telephone consultation). The note of this consultation contained some detail of Patient I's past medical history. The Tribunal was unable to determine whether Dr Webberley failed to elicit the details alleged or whether they were elicited and were simply not recorded.

296. Accordingly, the Tribunal found paragraphs 37ai1, 2 and 3, and 37aii of the Allegation not proved.

#### Paragraph 37b of the Allegation

37. Between 5 January 2018 and 23 March 2018, you failed to provide good clinical care to Patient I in that you:
- b. did not perform any physical or mental health examination; **Found not proved**

297. The Tribunal did not consider that the evidence demonstrated any particular reason for a physical and/or mental health examination with Patient I, given the fact that there had been a consultation. In reaching this conclusion the Tribunal had regard to the fact that the record showed that there was a blood test result available at this time and which Dr Webberley recorded, "*low total T and free T...*". The Tribunal did not have a copy of this laboratory result and therefore was unable to

determine whether the testosterone was truly low. If they were, this might have necessitated a physical examination, but as the Tribunal was unable to reach a conclusion in this regard it found the allegation not proved.

298. Accordingly, the Tribunal found paragraph 37b of the Allegation not proved.

#### Paragraphs 37ci and ii of the Allegation

37. Between 5 January 2018 and 23 March 2018, you failed to provide good clinical care to Patient I in that you:

c. inappropriately diagnosed Patient I with hypogonadism in that you failed to consider any:

i. alternative diagnosis; **Found not proved**

ii. likelihood that Patient I was seeking medication to build muscle mass rather than for therapeutic use; **Found not proved**

299. As the Tribunal has already noted, there was a consultation at which blood test results were available, and in respect of which Dr Webberley had recorded low testosterone levels. However, in the absence of the results themselves, the Tribunal was unable to determine whether the testosterone levels were truly low such as to suggest hypogonadism. Indeed, Dr Quinton's evidence was that, in the absence of baseline laboratory tests, he was unable to support or refute a diagnosis of hypogonadism. Furthermore, the Tribunal was unable to form a conclusion as to whether Dr Webberley had considered an alternative diagnosis or that the patient was merely seeking medication to build muscle mass, on the basis of the limited evidence before it.

300. Accordingly, the Tribunal found paragraph 37ci and ii of the Allegation not proved.

#### Paragraphs 37di, ii and iii of the Allegation

37. Between 5 January 2018 and 23 March 2018, you failed to provide good clinical care to Patient I in that you:

d. prescribed testosterone, anastrozole and mesterolone which was:

i. not clinically indicated; **Found proved**

ii. unsafe; **Found proved**

iii. not recognised as therapeutic practice in medicine; **Found proved**

301. The Tribunal considered that, whilst a prescription for testosterone alone may have been clinically indicated, it accepted Dr Quinton's evidence that even if Patient I had hypogonadism, the treatment regime of testosterone coupled with anastrozole and mestrelone did not have any recognised application in the treatment of male hypogonadism, or any recognised medical therapeutic purpose. Accordingly, it could not have been clinically indicated and it was unsafe to do so.

302. The Tribunal found paragraph 37di, ii and iii of the Allegation proved.

#### Paragraphs 37ei and ii of the Allegation

37. Between 5 January 2018 and 23 March 2018, you failed to provide good clinical care to Patient I in that you:

- e. did not order any tests for Patient I:
  - i. before commencing treatment; **Found not proved**
  - ii. during treatment; **Found not proved**

303. The Tribunal determined that tests were ordered for Patient I both before commencing treatment and during treatment. The medical notes for Patient I record a pre-treatment test on 27 December 2017 and a test during treatment on 23 March 2018.

304. Accordingly, the Tribunal found paragraphs 37ei and ii of the Allegation not proved.

#### Paragraphs 37f and 37gi and ii of the Allegation

37. Between 5 January 2018 and 23 March 2018, you failed to provide good clinical care to Patient I in that you:

- f. did not adequately communicate with Patient I in that you delegated communications to non-medically trained members of staff when it was inappropriate to do so; **Found not proved**
- g. did not provide adequate follow up care in that you:
  - i. failed to arrange a follow-up consultation with Patient I after treatment had commenced; **Found not proved**
  - ii. relied upon email communication between Patient I and non-clinical facilitators; **Found not proved**

305. The Tribunal was unable to conclude that there had been inadequate communication or inadequate follow up care as alleged given the obviously incomplete medical record before it.

306. Accordingly, the Tribunal found paragraphs 37f and 37gi and ii of the Allegation not proved.

Paragraphs 37hi, ii, iii and iv of the Allegation

37. Between 5 January 2018 and 23 March 2018, you failed to provide good clinical care to Patient I in that you:

- h. did not obtain informed consent from Patient I in that you failed to advise Patient I of:
  - i. the lack of evidence for therapeutic use for men with Patient I's presenting condition of the medication prescribed as set out at paragraph 37d;  
**Found not proved**
  - ii. the fact that the long-term risks associated with mesterolone treatment were unknown;  
**Found not proved**
  - iii. the risks associated with testosterone treatment;  
**Found not proved**
  - iv. the risks associated with anastrozole treatment;  
**Found not proved**

307. Similarly, as with the Tribunal's determination in respect of paragraphs 37f and 37g, the Tribunal was unable to determine whether Patient I's consent to treatment was 'informed' or not. There was nothing in the medical records to assist one way or the other in this regard.

308. Accordingly, the Tribunal found paragraphs 37hi, ii, iii and iv of the Allegation not proved.

Patient J

309. In respect of this patient, the Tribunal had Patient J's incomplete BMH medical records, and some patient contact notes from MHC relating to Patient J.

Paragraph 38a of the Allegation

38. Between 8 February 2018 and 7 November 2018, you failed to provide good clinical care to Patient J in that you:

- a. did not hold a consultation with Patient J; **Found proved**

310. For the same reasons as set out in relation to Patient A and other patients, the Tribunal determined that there should have been a consultation for the purpose of diagnosis and prior to the prescription of testosterone. In particular, Patient J's

questionnaire indicated that one of his principal concerns was an inability to obtain or maintain muscle and, in the Tribunal's judgement, this should have alerted Dr Webberley to the fact that this patient was not seeking testosterone for a *bona fide* medical condition.

311. The Tribunal determined that there was nothing to indicate that a consultation had occurred prior to diagnosis and prescription, rather it suggested that contact had been solely through email.

312. Accordingly, the Tribunal found paragraph 38a of the Allegation proved.

#### Paragraphs 38bi and ii of the Allegation

38. Between 8 February 2018 and 7 November 2018, you failed to provide good clinical care to Patient J in that you:
- b. did not elicit an adequate medical history, in that you failed to elicit details of:
    - i. history of anabolic steroid use; **Found proved**
    - ii. post cycle therapy; **Found proved**

313. The Tribunal noted that when Patient J attended MHC after he had ceased to be a patient of BMH and was seen by a doctor there, a medical history had apparently been obtained from Patient J and he had reported to the doctor previous anabolic steroid use and post-cycle therapy ('PCT'). Within BMH records, there was no evidence of a history being taken from Patient J beyond that contained within the patient questionnaire and Dr Webberley's patient summary, neither of which detailed Patient J's history of steroid use /PCT. The Tribunal found this paragraph proved and noted that, had a consultation occurred, as it should have done, this detail would have probably been elicited as had been done subsequently by the doctor at MHC.

314. Accordingly, the Tribunal found paragraph 38bi and ii of the Allegation proved.

#### Paragraph 38c of the Allegation

38. Between 8 February 2018 and 7 November 2018, you failed to provide good clinical care to Patient J in that you:
- c. did not perform any physical or mental health examination of Patient J; **Found proved**

315. In the case of Patient J, the Tribunal determined that a physical and mental health examination should have been conducted because, on the documentary material available to Dr Webberley, there was the possibility of androgen seeking behaviour, a history of testicular trauma, and a history of depressive behaviour.

There was no evidence of a physical or mental health examination was carried out and all communication with Patient J was carried out by email.

316. Accordingly, the Tribunal found paragraph 38c of the Allegation proved.

Paragraphs 38di, ii and iii of the Allegation

38. Between 8 February 2018 and 7 November 2018, you failed to provide good clinical care to Patient J in that you:
- d. inappropriately diagnosed Patient J with hypogonadism in that:
    - i. you failed to consider any alternative diagnosis; **Found proved**
    - ii. laboratory evidence did not support a diagnosis of hypogonadism; **Found proved**
    - iii. you failed to adequately investigate whether Patient J was seeking the medication primarily for the purpose of muscle-building, rather than for any clinical need; **Found proved**

317. The several blood tests obtained in relation to Patient J, prior to diagnosis and prescription, all showed normal levels of testosterone. The Tribunal accepted Dr Quinton's opinion that a diagnosis of hypogonadism 'flew in the face of the evidence available to Dr Webberley'. In these circumstances, Dr Webberley should have considered an alternative diagnosis of the symptoms being reported and in particular, as previously noted, the possibility that Patient J was demonstrating androgen seeking behaviour.

318. Accordingly, the Tribunal found paragraphs 38di, ii and iii of the Allegation proved.

Paragraphs 38ei and ii of the Allegation

38. Between 8 February 2018 and 7 November 2018, you failed to provide good clinical care to Patient J in that you:
- e. prescribed testosterone, hCG, exemestane and mesterolone which was:
    - i. not clinically-indicated; **Found proved**
    - ii. unsafe; **Found proved**

319. The Tribunal accepted the evidence of Dr Quinton that, on the information available to Dr Webberley, the possibility of hypogonadism was unequivocally

excluded and this, therefore, necessarily excluded any clinical indication for testosterone or hCG. In relation to mesterolone and exemestane Dr Quinton's opinion, which the Tribunal accepted, was that modern medicine had not identified any role for these drugs in the treatment of male hypogonadism under any circumstances. The Tribunal noted that not one of the four drugs prescribed to Patient J by Dr Webberley was clinically indicated, either alone, or in combination.

320. Accordingly, the Tribunal found paragraphs 38ei and ii of the Allegation proved.

Paragraph 38f of the Allegation

38. Between 8 February 2018 and 7 November 2018, you failed to provide good clinical care to Patient J in that you:

f. did not arrange all necessary tests for Patient J before reaching a diagnosis, including full blood count;

**Found proved**

321. The Tribunal accepted Dr Quinton's evidence that a full blood count test was mandatory before starting testosterone treatment because a finding of erythrocytosis would tend to exclude the possibility of hypogonadism and would also be an absolute contra indication of testosterone treatment. However, a full blood count test was not arranged.

322. Accordingly, the Tribunal found paragraph 38f of the Allegation proved.

Paragraph 38g of the Allegation

38. Between 8 February 2018 and 7 November 2018, you failed to provide good clinical care to Patient J in that you:

g. did not review Patient J's treatment plan when subsequent test results evidenced signs of over treatment of testosterone and hCG; **Found not proved**

323. In August 2017, Patient J, having been prescribed testosterone since June 2017, had a blood test performed that showed an abnormally high level of testosterone. Within the medical record there was evidence of Dr Webberley responding to these test results and recording that:

*"total T a bit high and suggested move to injection every 7 days..."*

324. The Tribunal concluded that Dr Webberley had reviewed Patient J's treatment plan, and the treatment plan was changed, although, as Dr Quinton had opined, it concluded that his response was inadequate.

325. Accordingly, the Tribunal found paragraph 38g of the Allegation not proved.

#### Paragraphs 38h and i of the Allegation

38. Between 8 February 2018 and 7 November 2018, you failed to provide good clinical care to Patient J in that you:
- h. did not adequately communicate with Patient J in that you failed to maintain regular correspondence; **Found not proved**
  - i. did not maintain adequate medical records throughout the period of treatment of Patient J. **Found not proved**

326. The Tribunal had noted that it had no witness evidence from Patient J and the medical records from BMH were evidently incomplete. For example, there was a single page of a patient contact record starting 16 August 2017, when it was otherwise evident that there must have been earlier contact with Patient J. Therefore, the Tribunal did not consider that it could infer from the incomplete record that there was either inadequate communication or a failure to maintain adequate medical records.

327. Accordingly, the Tribunal found paragraphs 38h and i of the Allegation not proved.

#### Paragraphs 39, 40, 41 and 42 of the Allegation

328. The Tribunal noted that that which is alleged in paragraphs 2, 3, 4 and 5, in relation to Patient A, mirrored that which is alleged at paragraphs 39, 40, 41 and 42 (with the exception of 39d and 40d). Additionally, that which is alleged at paragraphs 17d and 18d in relation to Patient D, mirrored that which is alleged at paragraphs 39d and 40d. Accordingly, for the reasons which it has already set out above, it found:

39. The Consent Forms provided to Patient J stated that:
- a. the higher limit of normal testosterone range was 40 nmol/L; **Found proved**
  - b. untreated hypogonadism can increase the risk of:
    - i. heart disease; **Found proved**
    - ii. Alzheimer's disease; **Found proved**
    - iii. premature death; **Found proved**
  - c. the treatment provided was TRT ; **Found proved**
  - d. Patient J will not take 'any type of anabolic steroid'. **Found proved**

40. You knew that the information in the Consent Forms was untrue as:
- a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **Found proved**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **Found not proved**
    - ii. Alzheimer's disease; **Found not proved**
    - iii. premature death; **Found not proved**
  - c. the treatment to be provided would increase testosterone above normal limits and was not TRT; **Found not proved**
  - d. you prescribed, or arranged to be prescribed, anabolic steroids to Patient J. **Found not proved**
41. Your conduct as set out at paragraph 39 was dishonest by reason of paragraph 40. **Found proved (in relation to 39a by reason of 40a)**
42. You did not obtain informed consent from Patient J for treatment you provided in that:
- a. you failed to counter-sign the Consent Forms; **Found not proved**
  - b. the Consent Forms contained statements which were untrue. **Found proved**

### **Patient K**

329. In respect of this patient, the Tribunal had medical records provided by BMH and some patient contact notes with MHC relating to Patient K. It did not however have direct witness evidence from Patient K.

### **Paragraphs 43ai, ii, iii, iv and v of the Allegation**

43. Between 13 March 2018 and 7 September 2018, you failed to provide good clinical care to Patient K in that you:
- a. consulted with Patient K on 21 March 2018 and you did not elicit an adequate medical history in that you:
    - i. inappropriately relied upon details obtained by a non-medically trained member of staff; **Found not proved**

- ii. failed to elicit details of sexual symptoms;  
**Found not proved**
- iii. failed to elicit details of non-sexual symptoms;  
**Found not proved**
- iv. failed to elicit details of Patient K's recent use of Clomiphene; **Found not proved**
- v. failed to recognise the degree of hypogonadal insufficiency based upon Patient K's previous diagnosis of testicular cancer; **Found not proved**

330. BMH's patient contact records contained a note from Mr MK, on 19 March 2018, providing minimal details regarding Patient F's medical history and referring Patient F to the doctor (Dr Webberley) for online consultation. It appeared that on this date a prescription was printed for testosterone and mestrelone. There was then a record of a consultation by Dr Webberley on 21 March 2018 (erroneously dated 21 August 2018), in which a more detailed medical history was recorded. It appeared that following this consultation the prescription printed on 19 March 2018 was signed by Dr Webberley.

331. With regard to paragraph 43ai, the Tribunal did not consider that the evidence disclosed that Dr Webberley had *relied* upon the details provided by Mr MK, although they had been provided to him. With regard to paragraphs 43aii, iii and iv, the Tribunal observed that Dr Webberley's note of the consultation did not contain reference to these details (although Patient F's recent use of Clomiphene was documented in earlier parts of the medical record). The Tribunal was not persuaded that the absence of reference to these matters in the note of consultation necessarily established that these matters were not elicited, they might well have been but were simply not documented.

332. With regard to paragraph 43av, the Tribunal considered whether or not Dr Webberley had failed to recognise the degree of hypogonadal insufficiency consequent upon Patient K's previous diagnosis of testicular cancer. The Tribunal determined that this was not a failure to elicit an adequate medical history in this regard. Further, Dr Webberley had elicited a history of previous testicular cancer and orchidectomy.

333. Accordingly, the Tribunal found paragraphs 43ai, ii, iii, iv and v of the Allegation not proved.

#### Paragraph 43b of the Allegation

- 43. Between 13 March 2018 and 7 September 2018, you failed to provide good clinical care to Patient K in that you:

- b. did not perform any physical or mental health examination;  
**Found proved**

334. The Tribunal accepted that there should have been a physical examination, based upon Dr Quinton's evidence and the fact that, given the history of orchidectomy, Dr Webberley should have established the volume of Patient F's remaining testes and he could not have done so with an online consultation.

335. Accordingly, the Tribunal found paragraph 43b of the Allegation proved.

#### Paragraph 43c of the Allegation

43. Between 13 March 2018 and 7 September 2018, you failed to provide good clinical care to Patient K in that you:

- c. diagnosed hypogonadism without identifying the correct sub-type of compensated primary hypogonadism;  
**Found proved**

336. The Tribunal accepted Dr Quinton's evidence that Dr Webberley's general diagnosis of hypogonadism was probably correct. However, Dr Webberley, in so doing, had failed to come to the overarching diagnosis that Patient K's most probably had 'compensated primary hypogonadism related to his past testicular cancer and its treatment'.

337. Accordingly, the Tribunal found paragraph 43c of the Allegation proved.

#### Paragraphs 43di and ii of the Allegation

43. Between 13 March 2018 and 7 September 2018, you failed to provide good clinical care to Patient K in that you:

- d. prescribed testosterone, hCG and mesterolone which was:
  - i. not clinically-indicated; **Found proved**
  - ii. unsafe; **Found proved**

338. Following the consultation with Patient K, Dr Webberley initially prescribed testosterone and hCG, and subsequently, in August 2018, prescribed testosterone, hCG and mesterolone in combination. The Tribunal accepted Dr Quinton's evidence that the prescription of testosterone alone may have been appropriate for primary hypogonadism, but the combination of drugs prescribed was not clinically indicated and was better characterised as a 'body builders' cocktail'. For reasons previously given this was unsafe.

339. Accordingly, the Tribunal found paragraphs 43di and ii of the Allegation proved.

#### Paragraph 43e of the Allegation

43. Between 13 March 2018 and 7 September 2018, you failed to provide good clinical care to Patient K in that you:

- e. did not review and adjust Patient K's prescribed medication when laboratory results revealed excessively high testosterone levels; **Found proved**

340. By May 2018, Patient K having been taking testosterone for approximately 6 weeks, had testosterone levels in his blood that were vastly raised (128 nmol/L NR:7.6-31.4). The Tribunal accepted the evidence of Dr Quinton that this result should have necessitated a review and adjustment of Patient K's medication. The Tribunal noted that Mr MK had recorded the test as being a 'peak (level) blood test' and in response, Dr Webberley referred to the need to obtain a 'trough' level blood test. However, he did not adjust Patient K's medication at this time. In Dr Quinton's opinion Dr Webberley should have immediately reduced or preferably ceased his medication. Dr Webberley did neither and by the end of June 2018 the testosterone levels had risen yet further (170 nmol/L). It was only after this that it would seem that some action was taken which resulted in a reduction in testosterone levels by July 2018.

341. Accordingly, the Tribunal found paragraph 43e of the Allegation proved.

#### Paragraphs 43fi and ii of the Allegation

43. Between 13 March 2018 and 7 September 2018, you failed to provide good clinical care to Patient K in that you:

- f. did not adequately arrange repeat tests in that you failed to:
  - i. specify the conditions under which blood should be drawn; **Found not proved**
  - ii. check Patient K's full blood count; **Found proved**

342. With regard to paragraphs 43fi and ii, the Tribunal accepted the evidence of Dr Quinton that Dr Webberley should have specified the conditions under which blood should have been drawn for the purposes for baseline tests and, during treatment, he should have been performing full blood counts and he failed to do so. In the Tribunal's judgement, full blood count tests were of particular importance given the significantly raised testosterone levels shown in the May and June 2018 blood tests and Dr Quinton's evidence in relation to the risk of androgen induced erythrocytosis.

343. The Tribunal, for the same reasons given in relation to other androgen patients, was unable to conclude that Dr Webberley or someone else had not specified to Patient K the conditions under which blood should be drawn. Although it was evident that a full blood count was not arranged.

344. Accordingly, the Tribunal found paragraphs 43fi not proved and 43f ii of the Allegation proved.

Paragraph 43g of the Allegation

43. Between 13 March 2018 and 7 September 2018, you failed to provide good clinical care to Patient K in that you:

- g. did not adequately communicate with Patient K in that you delegated communications to non-medically trained members of staff when it was not appropriate to do so;

**Found proved**

345. The Tribunal determined that Dr Webberley did not adequately communicate with Patient K, in particular, the Tribunal considered that following the markedly raised testosterone levels shown in the blood test from May 2018, Dr Webberley should have directly and immediately communicated with his patient.

346. Accordingly, the Tribunal found paragraph 43g of the Allegation proved.

Paragraph 43h of the Allegation

43. Between 13 March 2018 and 7 September 2018, you failed to provide good clinical care to Patient K in that you:

- h. did not provide adequate follow up care in that you relied entirely upon email communication between Patient K and non-clinical facilitators; **Found not proved**

347. The Tribunal considered that Dr Webberley's care of Patient K was inadequate. However, the medical records did not demonstrate that communication as between Patient K and the non-clinical facilitators was via email. Furthermore, the Tribunal noted that the patient contact record appeared to end in June 2018. Although there is other evidence within the medical record to demonstrate that there must have been contact between BMH and Patient K beyond this date, the Tribunal had no evidence as to what communications there were after this date or the form that they took.

348. Accordingly, the Tribunal found paragraph 43h of the Allegation not proved.

Paragraph 43i of the Allegation

43. Between 13 March 2018 and 7 September 2018, you failed to provide good clinical care to Patient K in that you:

- i. did not maintain an adequate record throughout the period of treatment of Patient K. **Found proved**

349. Despite the fact that the Tribunal did not have a record of patient contact beyond the end of June 2018, the records prior to that date, which included Dr Webberley's note of consultation, were in the Tribunal's view inadequate in terms of recording a full medical history or Dr Webberley's clinical decision making.

350. Accordingly, the Tribunal found paragraph 43i of the Allegation proved.

Paragraphs 44, 45, 46 and 47 of the Allegation

351. The Tribunal noted that that which is alleged in paragraphs 2, 3, 4 and 5, in relation to Patient A, mirrored that which is alleged at paragraphs 44, 45, 46 and 47 (with the exception of 44d and 45d). Additionally, that which is alleged at paragraphs 17d and 18d in relation to Patient D, mirrored that which is alleged at paragraphs 44d and 45d. Accordingly, for the reasons which it has already set out above, it found:

44. The Consent Forms provided to Patient K stated that:
  - a. the higher limit of normal testosterone range was 40 nmol/L;  
**Found proved**
  - b. untreated hypogonadism can increase the risk of:
    - i. heart disease; **Found proved**
    - ii. Alzheimer's disease; **Found proved**
    - iii. premature death; **Found proved**
  - c. the treatment provided was TRT; **Found proved**
  - d. Patient K will not take 'any type of anabolic steroid'.  
**Found proved**
45. You knew that the information in the Consent Forms was untrue as:
  - a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **Found proved**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **Found not proved**
    - ii. Alzheimer's disease; **Found not proved**
    - iii. premature death; **Found not proved**

- c. the treatment to be provided would increase testosterone above normal limits and was not TRT; **Found not proved**
  - d. you prescribed, or arranged to be prescribed, anabolic steroids to Patient K. **Found not proved**
46. Your conduct as set out at paragraph 44 was dishonest by reason of paragraph 45. **Found proved (in relation to 44a by reason of 45a)**
47. You did not obtain informed consent from Patient K for treatment you provided in that:
- a. you failed to counter-sign the Consent Forms; **Found not proved**
  - b. the Consent Forms contained statements which were untrue. **Found proved**

### Patient L

352. In respect of this patient, the Tribunal had evidence from Patient L together with Patient L's BMH medical notes, and a contact note from MHC relating to Patient L.

### Paragraph 48a of the Allegation

48. Between 8 March 2018 and 9 October 2018, you failed to provide good clinical care to Patient L in that you:
- a. consulted with Patient L on 8 March 2018 and failed to:
    - i. elicit an adequate medical history in that you did not elicit details of Patient L's LS;
      - 1. history of anabolic steroid use; **Found not proved**
      - 2. post-cycle therapy; **Found not proved**
    - ii. document basic clinical observations; **Found proved**
    - iii. adequately explain to Patient L:
      - 1. how to safely administer testosterone injections; **Found proved**
      - 2. the risks associated with proposed treatment options; **Found proved**

353. As to paragraphs 48ai1 and 2, the Tribunal noted Dr Webberley's note of this consultation which occurred on 8 March 2018, and which recorded:

*"at 17 experimented with steroids and PCT for about 4-6 weeks".*

354. By reference to the history Patient L gave to a doctor at MHC subsequent to this consultation, and before Patient L gave a witness statement to the GMC (in which Patient L made no reference to steroids), it was apparent that the reference to 'steroids' in Dr Webberley's note of his consultation was in relation to anabolic steroids.

355. Dr Quinton nevertheless criticised Dr Webberley for not having 'drilled down' on the history of anabolic steroid history abuse and PCT. This was not an inference that the Tribunal was able to make as there plainly had been discussion as to Patient L's history of steroid abuse and PCT and the evidence was equally consistent with Dr Webberley having maintained an inadequate record of that discussion as with there having been no *adequate* discussion.

356. Accordingly, the Tribunal found paragraph 48ai1 and 2 not proved.

357. In relation to paragraph 48aii, the Tribunal determined that by reference to Dr Webberley's note of the consultation that he did not *document* basic clinic observations, as the Tribunal accepted he should have done. For example, there was no record whether Patient L appeared generally well or unwell, was abnormally slim or obese, whether he was anxious or depressed, and whether he was heavily muscled or not (the latter being potentially indicative of androgen abuse).

358. Accordingly, the Tribunal found paragraph 48aii proved.

359. In relation to paragraph 48aiii1, the Tribunal noted that the record of consultation recorded that Patient L was:

*"not comfortable about administering injections / would like a nurse".*

360. Patient L's evidence was that there had been no real discussion about any injection protocol, and it was only subsequently he was sent information explaining how to administer testosterone injections. The Tribunal determined, that in the light of Patient L's reservations as recorded in the consultation note, Dr Webberley should have explained how to safely administer testosterone injections at the consultation itself and had not done so.

361. Accordingly, the Tribunal found paragraph 48aiii1 proved.

362. As to 48aiii2, the consultation record does not refer to any discussion with Patient L regarding any risks associated with the proposed treatment. Patient L's evidence was that Dr Webberley had explained the risk of infertility as a result of an exogenous testosterone prescription, but no other risks were detailed by Patient L as having been discussed with Dr Webberley. As has previously been stated there

are other risks associated with this treatment that should have been explained to Patient L.

363. Accordingly, the Tribunal found paragraph 48aiii2 proved.

#### Paragraph 48b of the Allegation

48. Between 8 March 2018 and 9 October 2018, you failed to provide good clinical care to Patient L in that you:

- b. did not estimate Patient L's testicular volumes as part of a physical examination; **Found proved**

364. Neither Patient L or the note of Dr Webberley's consultation on 8 March 2018 indicated that there was any physical examination, either of the testicles or otherwise. The Tribunal considered that, in the circumstances of this case, there should have been a physical examination of the testicles when there was an opportunity to do so on 8 March 2018, if for no other reason than the fact that there had been disclosed to Dr Webberley the fact of previous anabolic steroid use.

365. Accordingly, the Tribunal found paragraph 48b of the Allegation proved.

#### Paragraphs 48ci, ii and iii of the Allegation

48. Between 8 March 2018 and 9 October 2018, you failed to provide good clinical care to Patient L in that you:

- c. inappropriately diagnosed Patient L with hypogonadism in that:
  - i. clinical evidence for hypogonadism was inadequately investigated: **Found proved**
  - ii. you failed to consider any alternative diagnosis; **Found proved**
  - iii. laboratory evidence did not support a diagnosis of hypogonadism; **Found proved**

366. The Tribunal noted that Dr Webberley first prescribed Patient L with testosterone, hCG and mesterolone on 21 February 2018. As at this date, the only clinical evidence that BMH had was the content of an online questionnaire provided by Patient L on this date, and the results of three recently obtained laboratory blood tests all of which, according to Dr Quinton, showed normal levels of testosterone. On the basis that Dr Webberley must have diagnosed hypogonadism prior to issuing the prescription on 21 February 2018, the Tribunal determined that there was at that time no clinical evidence to support such a diagnosis. Further, despite evidence available on that date that Patient L might have had relevant mental health issues and potentially, in the light of a history of anabolic steroid use, there was no

evidence that Dr Webberley considered any alternative diagnosis that may have been relevant to Patient L's stated concerns regarding self-confidence, energy levels, body image and sexual functioning.

367. Accordingly, the Tribunal found paragraphs 48ci, ii and iii of the Allegation proved.

#### Paragraphs 48di and ii of the Allegation

48. Between 8 March 2018 and 9 October 2018, you failed to provide good clinical care to Patient L in that you:

d. prescribed testosterone, hCG and mesterolone which was:

i. not clinically indicated; **Found proved**

ii. unsafe; **Found proved**

368. The Tribunal, having found that there was no evidence to support a diagnosis of hypogonadism, considered that it necessarily followed that the prescription of testosterone, hCG and mesterolone was not clinically indicated. The Tribunal accepted Dr Quinton's opinion that these drugs were not clinically indicated, either singularly or in combination. For these reasons, and the reasons given in relation to previous patients, it was unsafe to do so.

369. Accordingly, the Tribunal found paragraphs 48di and ii of the Allegation proved.

#### Paragraphs 48ei and ii of the Allegation

48. Between 8 March 2018 and 9 October 2018, you failed to provide good clinical care to Patient L in that you:

e. did not adequately communicate with Patient L in that you:

i. failed to maintain regular contact during the course of Patient L's treatment; **Found proved**

ii. delegated communications with Patient L to non-medically trained staff when it was not appropriate to do so; **Found proved**

370. Unlike some of the other patients, the Tribunal considered BMH's medical notes in relation to Patient L appeared to be substantial. In particular, the Tribunal noted that they included a chronological patient contact record, with the exception of one entry in which it appeared that Dr Webberley was endorsing a decision made by Mr MK (a non-medically qualified member of staff), and Dr Webberley's note of the consultation on 8 March 2018, there was an absence of any recorded contacts or communications between Dr Webberley and his patient, Patient L. Although

there were numerous contacts between Patient L and non-medically trained staff. Also within the record were two emails from Dr Webberley but these did not directly relate to his care.

371. Accordingly, the Tribunal found paragraphs 48ei and ii of the Allegation proved.

#### Paragraphs 48fi and ii of the Allegation

48. Between 8 March 2018 and 9 October 2018, you failed to provide good clinical care to Patient L in that you:

- f. did not review during treatment:
  - i. feedback from Patient L regarding his treatment;  
**Found proved**
  - ii. Patient L's laboratory results; **Found proved**

372. The Tribunal, having considered Patient L's medical notes in their entirety and, in particular, the chronological patient contact record, determined, on the balance of probabilities that, Dr Webberley had not reviewed Patient L's treatment following either the feedback from Patient L regarding his treatment or his laboratory test results. The Tribunal determined, accepting Dr Quinton's evidence, that he should have done both.

373. Accordingly, the Tribunal found paragraphs 48fi and ii of the Allegation proved.

#### Paragraph 48g of the Allegation

48. Between 8 March 2018 and 9 October 2018, you failed to provide good clinical care to Patient L in that you:

- g. did not provide any oversight to non-medical members of staff  
advising Patient L on clinical matters during his treatment;  
**Found not proved**

374. The Tribunal, having considered Patient L's medical notes, found minimal evidence of oversight exercised by Dr Webberley over non-medical members of staff. However, there was at least one occasion when Dr Webberley appeared to have considered and endorsed a decision made by a non-medical member of staff, Mr MK, in relation to Patient L's treatment. Accordingly, the Tribunal was not satisfied that Dr Webberley had not provided 'any' oversight.

375. Accordingly, the Tribunal found paragraph 48g of the Allegation not proved.

#### Paragraphs 48hi and ii of the Allegation

48. Between 8 March 2018 and 9 October 2018, you failed to provide good clinical care to Patient L in that you:
- h. following receipt of results which indicated treatment was ineffective, did not:
    - i. suspend or reduce medication; **Found proved**
    - ii. review the original diagnosis; **Found proved**

376. The Tribunal accepted the evidence of Dr Quinton that blood test results obtained following treatment indicated that there had been no clear benefit to Patient L, and that they unequivocally demonstrated over treatment with testosterone and hCG. The Tribunal also accepted Dr Quinton's evidence that, in these circumstances, Dr Webberley ought to have suspended or, at the very, least reduced the dosage and that he should have reviewed the original diagnosis. In fact, Dr Webberley did neither, on the contrary, Dr Webberley encouraged Patient L to continue by issuing an identical repeat prescription on 4 September 2018.

377. Accordingly, the Tribunal found paragraphs 48hi and ii of the Allegation proved.

#### Paragraph 48i of the Allegation

48. Between 8 March 2018 and 9 October 2018, you failed to provide good clinical care to Patient L in that you:
- i. did not arrange all necessary tests for Patient L;  
**Found proved**

378. The Tribunal accepted Dr Quinton's evidence that LH and FSH levels should be determined at some stage as part of the 'work up' of a suspected diagnosis of hypogonadism, and also that a full blood count should be undertaken. Dr Webberley did neither in respect of Patient L.

379. Accordingly, the Tribunal found paragraph 48i of the Allegation proved.

#### Paragraph 48j of the Allegation

48. Between 8 March 2018 and 9 October 2018, you failed to provide good clinical care to Patient L in that you:
- j. did not maintain adequate medical records throughout the period of treatment of Patient L. **Found proved**

380. The Tribunal reminded itself that although Patient L had entered into an agreement with BMH, Patient L was the patient of Dr Webberley, and it was Dr Webberley who was responsible for Patient L's clinical care in respect of which he

should have maintained an adequate medical record. The Tribunal, having considered Patient L's medical notes, found that they contained comprehensive records of interactions between BMH's non-clinical staff and Patient L. However, there were minimal clinical records concerning Dr Webberley's care of Patient L. They were limited to a note of the consultation on 8 March 2018 and an apparent endorsement by Dr Webberley of what appeared to be a treatment decision by Mr MK.

381. Further, although not necessary for the purpose of its determination in relation to this paragraph, the Tribunal noted that the records suggested that Dr Webberley apparently made a diagnosis and then prescribed testosterone on 21 February 2018, some two weeks before his initial consultation with Patient L on 8 March 2018.

382. Accordingly, the Tribunal found paragraph 48j of the Allegation proved.

#### Paragraphs 49, 50, 51 and 52 of the Allegation

383. The Tribunal noted that that which is alleged in paragraphs 2, 3, 4 and 5, in relation to Patient A, mirrored that which is alleged at paragraphs 49, 50, 51 and 52 (with the exception of 49d and 50d). Additionally, that which is alleged at paragraphs 17d and 18d in relation to Patient D, mirrored that which is alleged at paragraphs 49d and 50d. Accordingly, for the reasons which it has already set out above, it found:

49. The Consent Forms provided to Patient L stated that:
  - a. the higher limit of normal testosterone range was 40 nmol/L;  
**Found proved**
  - b. untreated hypogonadism can increase the risk of:
    - i. heart disease; **Found proved**
    - ii. Alzheimer's disease; **Found proved**
    - iii. premature death; **Found proved**
  - c. the treatment provided was TRT; **Found proved**
  - d. Patient L will not take 'any type of anabolic steroid'.  
**Found proved**
50. You knew that the information in the Consent Form was untrue as:
  - a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **Found proved**

- b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **Found not proved**
    - ii. Alzheimer's disease; **Found not proved**
    - iii. Premature death; **Found not proved**
  - c. the treatment to be provided would increase testosterone above normal limits and was not TRT; **Found not proved**
  - d. you prescribed, or arranged to be prescribed, anabolic steroids to Patient L. **Found not proved**
51. Your conduct as set out at paragraph 49 was dishonest by reason of paragraph 50. **Found proved (in relation to 49a by reason of 50a)**
52. You did not obtain informed consent from Patient L for treatment you provided in that:
- a. you failed to counter-sign the Consent Forms; **Found not proved**
  - b. the Consent Forms contained statements which were untrue. **Found proved**

### **Patient M**

384. In respect of this patient, the Tribunal had Patient M's BMH medical records and a contact note from MHC relating to Patient M.

### **Paragraphs 53ai, ii and iii of the Allegation**

53. Between March 2018 and 31 August 2018, you failed to provide good clinical care to Patient M in that you:
- a. consulted with Patient M on 24 April 2018 and failed to elicit an adequate medical history in that you:
    - i. relied upon details obtained by a non-medically trained member of staff; **Found not proved**
    - ii. failed to elicit details of sexual symptoms; **Found not proved**
    - iii. failed to elicit details of non-sexual symptoms; **Found not proved**

385. The Tribunal noted that prior to Patient M's consultation with Dr Webberley on 24 April 2018, he would have had access to the client information form apparently obtained by a non-medically trained member of staff. Much of the information in Dr Webberley's note of the consultation was similar to the information previously obtained. However, the consultation note did contain additional information and referred to discussions on matters not covered on the client information form. In these circumstances, the Tribunal could not be satisfied that Dr Webberley had merely relied upon details obtained by non-medically members of staff.

386. With regards to paragraph 53a ii and iii, the Tribunal was unable to conclude whether Dr Webberley had failed to elicit details as alleged, or simply failed to record his having elicited such details, therefore 53a ii and iii not proved.

387. Accordingly, the Tribunal found paragraphs 53a i, ii and iii of the Allegation not proved.

#### Paragraph 53b of the Allegation

53. Between March 2018 and 31 August 2018, you failed to provide good clinical care to Patient M in that you:

- b. did not perform any physical or mental health examination;  
**Found not proved**

388. Having considered the available medical records, and with reference to the consultation entry on 24 April 2018, the Tribunal was unable to determine whether this remote consultation was by either telephone or video conference. The Tribunal, had already determined in relation to other patients, that sometimes it is unnecessary to perform a physical or mental health examination provided the doctor has the opportunity to 'eyeball' the patient, and the medical history of that particular patient does not demand a physical or mental examination. In this case, the Tribunal could not be satisfied that such a physical or mental health examination was required, and it could not determine, on the evidence available, whether the consultation was conducted via video link.

389. Accordingly, the Tribunal found paragraph 53b of the Allegation not proved.

#### Paragraphs 53c i, ii and iii of the Allegation

53. Between March 2018 and 31 August 2018, you failed to provide good clinical care to Patient M in that you:

- c. inappropriately diagnosed Patient M with hypogonadism in that:
  - i. the diagnosis was not supported by laboratory results;  
**Found proved**

- ii. you failed to consider any alternative diagnosis;  
**Found proved**
- iii. you failed to refer to evidence which suggested Patient M was seeking medication for androgen abuse;  
**Found not proved**

390. The laboratory blood tests available at the time of Dr Webberley's consultation with Patient M, and his prescription of testosterone, did not support a diagnosis of hypogonadism in the opinion of Dr Quinton which the Tribunal accepted. Furthermore, the Tribunal noted Dr Webberley's note of consultation which referred to:

*"...borderline results [they were normal], I think it is worth a trial of low dose TRT..."*

391. Therefore, the Tribunal accepted that a diagnosis of hypogonadism was inappropriate. The fact that Patient M was reporting numerous other symptoms, in the Tribunal's judgement, required Dr Webberley to consider alternative diagnoses and there was no evidence that he did. Accordingly, the Tribunal found paragraph 53ci and ii proved.

392. As to paragraph 53ciii, the Tribunal having reviewed the medical notes, did not consider that there was any specific evidence available to Dr Webberley which suggested that Patient M was seeking medication for androgen abuse. In this regard, the Tribunal did not consider that the mere fact that it was known in August 2018 that Patient M 'read forums on the internet' [relating to androgens], was sufficient basis for a contrary conclusion.

393. Accordingly, the Tribunal found paragraph 53ciii of the Allegation not proved.

#### Paragraphs 53di and ii of the Allegation

53. Between March 2018 and 31 August 2018, you failed to provide good clinical care to Patient M in that you:

- d. prescribed testosterone and mesterolone which was:
  - i. not clinically indicated; **Found proved**
  - ii. unsafe; **Found proved**

394. As the Tribunal had already found, there was insufficient evidence to support a diagnosis of hypogonadism and therefore, a prescription of testosterone was necessarily excluded as an appropriate treatment. Further, the Tribunal accepted Dr Quinton's opinion evidence that mesterolone had no role in the treatment of male hypogonadism. Therefore, the prescription of the drugs was not clinically indicated, either alone, or in combination, and was unsafe.

395. Accordingly, the Tribunal found paragraphs 53di and ii of the Allegation proved.

Paragraphs 53ei and ii of the Allegation

53. Between March 2018 and 31 August 2018, you failed to provide good clinical care to Patient M in that you:

- e. did not conduct tests adequately in that you failed to:
  - i. specify the conditions under which blood should be drawn; **Found not proved**
  - ii. check Patient M's full blood count for haematocrit; **Found proved**

396. In relation to paragraph 53ei, the Tribunal, having considered BMH's patient record in respect of Patient M, were unable to conclude whether or not Dr Webberley had specified the conditions under which Patient M should have his blood drawn. Furthermore, the Tribunal noted within the medical record that there was an entry for 17 August 2018 indicating that attention was being given by BMH as to the conditions, including the time of day, at which blood was being drawn for the purpose of a blood test.

397. Accordingly, the Tribunal found paragraph 53ei of the Allegation not proved.

398. As to paragraph 53eii, the Tribunal noted that a full blood count was performed in relation to Patient M's first pre-prescription blood test. However, subsequent blood tests post prescription did not include a full blood count which they should have done for the purpose of monitoring haematocrit levels.

399. Accordingly, the Tribunal found paragraph 53eii of the Allegation proved.

Paragraph 53f of the Allegation

53. Between March 2018 and 31 August 2018, you failed to provide good clinical care to Patient M in that you:

- f. did not review Patient M's treatment plan when subsequent test results evidenced signs of over treatment of testosterone; **Found not proved**

400. The Tribunal noted that, two blood tests in June and August 2018, demonstrated elevated levels of testosterone evidencing possible over treatment of testosterone. However, on 22 August 2018 Dr Webberley recorded an improvement in Patient M's symptoms whilst noting testosterone was elevated, as a result of which, he suggested reducing the dose [of testosterone] and repeating blood tests in 6 weeks 'to make sure that levels have come down'. In these circumstances, the

Tribunal concluded that Dr Webberley did review the treatment plan and it found paragraph 53f not proved.

401. Accordingly, the Tribunal found paragraph 53f of the Allegation not proved.

#### Paragraph 53g of the Allegation

53. Between March 2018 and 31 August 2018, you failed to provide good clinical care to Patient M in that you:

- g. did not adequately communicate with Patient M in that you delegated communications to non-medically trained members of staff when it was inappropriate to do so. **Found proved**

402. There was no evidence of Dr Webberley communicating directly with Patient M other than in respect of the single consultation on 24 April 2018. This was despite the fact that there were issues that arose during the course of Patient M's treatment, for example, symptoms of over treatment with testosterone. The Tribunal determined that, in these circumstances, it was inappropriate for communication with Patient M to be delegated to non-medically trained members of staff in Patient M's case.

403. Accordingly, the Tribunal found paragraph 53g of the Allegation proved.

#### Paragraphs 54, 55, 56 and 57 of the Allegation

404. The Tribunal noted that that which is alleged in paragraphs 2, 3, 4 and 5, in relation to Patient A, mirrored that which is alleged at paragraphs 54, 55, 56 and 57 (with the exception of 17d and 18d). Additionally, that which is alleged at paragraphs 17d and 18d in relation to Patient D, mirrored that which is alleged at paragraphs 54d and 55d. Accordingly, for the reasons which it has already set out above, it found:

54. The Consent Forms provided to Patient M stated that:

- a. the higher limit of normal testosterone range was 40 nmol/L; **Found proved**
- b. untreated hypogonadism can increase the risk of:
  - i. heart disease; **Found proved**
  - ii. Alzheimer's disease; **Found proved**
  - iii. premature death; **Found proved**
- c. the treatment provided was TRT; **Found proved**

- d. Patient M will not take 'any type of anabolic steroid'.  
**Found proved**
55. You knew that the information in the Consent Forms was untrue as:
- a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **Found proved**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **Found not proved**
    - ii. Alzheimer's disease; **Found not proved**
    - iii. premature death; **Found not proved**
  - c. the treatment to be provided would increase testosterone above normal limits and was not TRT; **Found not proved**
  - d. you prescribed, or arranged to be prescribed, anabolic steroids to Patient M. **Found not proved**
56. Your conduct as set out at paragraph 54 was dishonest by reason of paragraph 55. **Found proved (in relation to 54a by reason of 55a)**
57. You did not obtain informed consent from Patient M for treatment you provided in that:
- a. you failed to counter-sign the Consent Forms;  
**Found not proved**
  - b. the Consent Forms contained statements which were untrue.  
**Found proved**

### **Patient N**

405. In respect of this patient, the Tribunal had direct evidence from Patient N together with Patient N's limited BMH medical notes, and a contact note from MHC relating to Patient N.

### **Paragraph 58a of the Allegation**

58. Between 25 April 2018 and 19 November 2018, you failed to provide good clinical care to Patient N in that you:
- a. did not hold a consultation with Patient N; **Found proved**

406. For the reasons given in relation to previous patients, Dr Webberley should have had a consultation with Patient N in the context previously described. The evidence of Patient N confirms that no such consultation took place.

407. Accordingly, the Tribunal found paragraph 58a of the Allegation proved.

Paragraphs 58bi, ii and iii of the Allegation

58. Between 25 April 2018 and 19 November 2018, you failed to provide good clinical care to Patient N in that you:

b. did not elicit an adequate medical history in that you did not elicit details of:

i. sexual symptoms; **Found proved**

ii. non-sexual symptoms; **Found proved**

iii. answers to general health questions concerning the presenting complaint; **Found proved**

408. The medical history elicited by Dr Webberley from Patient N was limited to an email response by Patient N to a number of cursory questions such as:

*“are you fit and healthy?”*

*“any problems with water works/ prostate?”*

*“any medication?”*

*“anything that runs in the family?”.*

409. The Tribunal accepted the evidence of Dr Quinton that this single ‘scattershot’ enquiry did not constitute the eliciting of an adequate medical history as to the matters outlined in 58bi, ii and iii, a conclusion that the Tribunal would have reached in any event.

410. Accordingly, the Tribunal found paragraphs 58bi, ii and iii of the Allegation proved.

Paragraph 58c of the Allegation

58. Between 25 April 2018 and 19 November 2018, you failed to provide good clinical care to Patient N in that you:

c. relied upon the responses of Patient N to inadequate email enquiries as the basis for clinical decision-making;  
**Found proved**

411. Following consideration of the email correspondence as between Patient N and Dr Webberley/ GenderGP, and in the absence of any other material upon which

clinical decisions might have been made, the Tribunal found paragraph 58c of the Allegation proved.

Paragraph 58d of the Allegation

58. Between 25 April 2018 and 19 November 2018, you failed to provide good clinical care to Patient N in that you:

- d. did not perform any physical or mental health examination of Patient N; **Found proved**

412. In the case of Patient N, unlike some of the other patients that the Tribunal considered, there was email correspondence between Patient N and Dr Webberley/GenderGP which demonstrated that Patient N was reporting a variety of different symptoms, both physical and mental health, and there had also been a number of blood tests. Furthermore, the Tribunal considered that there were indications within Patient N's communications with Dr Webberley/GenderGP that he might be someone who was displaying androgen seeking behaviour. In particular, in the manner in which he sought to dictate to Dr Webberley how he wanted his testosterone.

413. In these circumstances the Tribunal determined that Dr Webberley should have conducted both a physical and mental health examination before prescribing.

414. Accordingly, the Tribunal found paragraph 58d of the Allegation proved.

Paragraphs 58ei, ii and iii of the Allegation

58. Between 25 April 2018 and 19 November 2018, you failed to provide good clinical care to Patient N in that you:

- e. inappropriately diagnosed Patient N with hypogonadism in that:
  - i. the diagnosis was contrary to laboratory results; **Found proved**
  - ii. you failed to consider any underlying causes for the laboratory results; **Found proved**
  - iii. you failed to consider any alternative diagnosis; **Found proved**

415. The laboratory results for the blood tests obtained in respect of Patient N showed normal levels of testosterone and were therefore not consistent with the diagnosis of hypogonadism. Furthermore, the levels of haemoglobin and haematocrit were at the 'high end of normal', results which were incompatible with a diagnosis of hypogonadism. The Tribunal accepted the evidence of Dr Quinton that, in the light of the overall test results that included altered liver function tests,

Dr Webberley should have given consideration to the causes of these results. The Tribunal was satisfied on the evidence that he failed to do so. Further, and necessarily he failed to consider any alternative diagnosis because all he did was prescribe the testosterone requested by Patient N.

416. Accordingly, the Tribunal found paragraphs 58ei, ii and iii of the Allegation proved.

Paragraphs 58fi1 and 2 and 58fii of the Allegation

58. Between 25 April 2018 and 19 November 2018, you failed to provide good clinical care to Patient N in that you:

- f. prescribed Patient N with testosterone:
  - i. which was:
    - 1. not clinically indicated; **Found proved**
    - 2. unsafe; **Found proved**
  - ii. without explaining the risks and benefits to Patient N; **Found proved**

417. In respect of paragraph 58fi1 and 2, for the same reasons in relation to those set out in relation to paragraph 58ei, and for the reasons given in respect of other patients, the Tribunal found paragraph 58fi1 and 2 proved.

418. In respect of paragraph 58fii, the Tribunal considered the correspondence contained within Patient N's medical notes provided by GenderGP which constituted largely of blood tests results and emails correspondence, the latter of which appeared to represent the extent of the communication between Patient N and Dr Webberley/GenderGP. The Tribunal also considered the email correspondence produced by Patient N. There was an absence of any explanation as to the risks and benefits to Patient N of the proposed testosterone treatment. Furthermore, the Tribunal noted that in this case, androgen treatment was being provided to Patient N through GenderGP and not BMH. Other patients that the Tribunal had considered and who had received treatment from BMH had, on occasions, received some leaflets dealing with risks and benefits. In these circumstances, the Tribunal found paragraph 58fii of the Allegation proved.

Paragraphs 58gi, ii and iii of the Allegation

58. Between 25 April 2018 and 19 November 2018, you failed to provide good clinical care to Patient N in that you:

- g. increased the original dosage of prescribed testosterone from 11.9 mg/day to 25mg/day:

- i. without any clinical basis for doing so;  
**Found proved**
- ii. when Patient N suggested seeking the services of another provider if the dosage wasn't increased;  
**Found proved**
- iii. knowing that in doing so you were supporting Patient N's abuse of testosterone medication;  
**Found proved**

419. The Tribunal accepted the evidence of Dr Quinton that the treatment regime initially proposed by Dr Webberley, even assuming that the diagnosis of hypogonadism was correct, was certain to result in androgen induced erythrocytosis with the attendant risks of that condition. However, email correspondence as between Patient N and Dr Webberley, in May 2018, demonstrated that Patient N requested Dr Webberley to prescribe more than double the dose Dr Webberley had initially proposed. Dr Webberley replied stating "*ok, I shall get this sorted for you*", and issued a prescription as had been requested by Patient N.

420. The Tribunal considered this correspondence striking and unusual in the context of a doctor/patient relationship given that it showed the patient was dictating to the doctor what medication he required. Dr Webberley simply complied with the request without regard to any clinical need.

421. Accordingly, the Tribunal found paragraphs 58gi, ii and iii of the Allegation proved.

Paragraphs 58hi, ii and iii of the Allegation

58. Between 25 April 2018 and 19 November 2018, you failed to provide good clinical care to Patient N in that you:

- h. did not adequately communicate with Patient N in that you did not:
  - i. maintain regular contact during the course of Patient N's treatment; **Found proved**
  - ii. respond to concerns raised by Patient N in July 2018 relating to symptoms characteristic of over treatment of testosterone; **Found proved**
  - iii. delegated communications with Patient N to non-medically trained staff when it was not appropriate to do so; **Found proved**

422. The Tribunal, having reviewed the communications as between Patient N and Dr Webberley, determined that he had not maintained regular contact with

Patient N during the course of his treatment and, in particular in July 2018, when Patient N reported a series of symptoms characteristic with over treatment of testosterone (this was unsurprisingly given the excessive dose that Dr Webberley had prescribed) and inquiring whether he should reduce the dose of testosterone.

423. Rather than responding and giving advice, Dr Webberley did not reply and continued to issue prescriptions.

424. Accordingly, the Tribunal found paragraphs 58hi and ii of the Allegation proved.

425. In relation to paragraph 58hiii, the Tribunal noted that, particularly in respect of emails sent by Patient N in July 2018 in which Patient N was reporting side effects from his testosterone treatment, responses on behalf of BMH were from non-medically trained staff and, in the circumstances, it was plainly inappropriate for them to be dealing with this issue and it should have been Dr Webberley.

426. Accordingly, the Tribunal found paragraphs 58hiii of the Allegation proved.

#### Paragraph 58i of the Allegation

58. Between 25 April 2018 and 19 November 2018, you failed to provide good clinical care to Patient N in that you:

- i. did not provide any oversight on clinical matters to non-medical members of staff advising Patient N during his treatment; **Found not proved**

427. The Tribunal considered that the oversight by Dr Webberley, as demonstrated in the medical records, was plainly inadequate. However, the emails between Patient N and members of staff at BMH did indicate that Dr Webberley, on occasion, was interacting with the staff in relation to Patient N's care. Accordingly, the Tribunal was unable to conclude that there had not been any oversight.

428. Accordingly, the Tribunal found paragraph 58i of the Allegation not proved.

#### Paragraph 58j of the Allegation

58. Between 25 April 2018 and 19 November 2018, you failed to provide good clinical care to Patient N in that you:

- j. inappropriately agreed not to inform Patient N's general practitioner of your care and treatment; **Found not proved**

429. Dr Quinton was to concede during the course of oral evidence that, a patient who is receiving care from a private practitioner is entitled to withhold consent for their general practitioner to be informed of the care and treatment they are receiving from the private practitioner. A private practitioner has a choice as to

whether they consider it appropriate to give treatment to a patient without the patient's GP's knowledge, but that was not the issue before this Tribunal.

430. Accordingly, the Tribunal found paragraph 58j of the Allegation not proved.

Paragraphs 58ki and ii of the Allegation

58. Between 25 April 2018 and 19 November 2018, you failed to provide good clinical care to Patient N in that you:

k. did not review:

i. Patient N's further laboratory results received once treatment commenced; **Found proved**

ii. Patient N's treatment plan following concerns raised regarding possible over treatment of testosterone as set out at paragraph 58h.ii above; **Found proved**

431. For the same reasons as set out in relation to paragraphs 58hi, ii and iii, the Tribunal found paragraphs 58ki and ii of the Allegation proved.

Paragraph 58l of the Allegation

58. Between 25 April 2018 and 19 November 2018, you failed to provide good clinical care to Patient N in that you:

l. did not maintain adequate medical records throughout the period of treatment of Patient N. **Found proved**

432. The Tribunal, having considered the medical records in relation to Patient N, determined that they were plainly inadequate. There was a paucity of clinical information with regard to Patient N, in particular, in respect of Dr Webberley's clinical decision making and which should have been included within the medical records.

433. Accordingly, the Tribunal found paragraph 58l of the Allegation proved.

**Patient O**

434. In respect of this patient, the Tribunal had Patient O's BMH medical records and contact notes from MHC relating to Patient O.

Paragraphs 59ai, ii, iii, iv and v of the Allegation

59. Between 15 May 2018 and 29 December 2018, you failed to provide good clinical care to Patient O in that you:

- a. consulted with Patient O on 15 May 2018 and you did not elicit an adequate medical history in that you:
  - i. inappropriately relied upon details obtained by a non-medically trained member of staff; **Found not proved**
  - ii. failed to reconcile contradictory statements given by Patient O previously regarding his medical history; **Found not proved**
  - iii. failed to ask any general health questions concerning the presenting complaint; **Found not proved**
  - iv. failed to elicit details of Patient O's psychological background; **Found not proved**

435. There was a relatively full note of the consultation between Dr Webberley and Patient O on 15 May 2018 and which included some medical history. The Tribunal was unable to determine whether Dr Webberley failed to elicit an adequate medical history as to the facts alleged, or whether he did elicit an adequate medical history, but failed to record it adequately.

436. Accordingly, the Tribunal found paragraphs 59ai, ii, iii, iv and v of the Allegation not proved.

#### Paragraph 59b of the Allegation

59. Between 15 May 2018 and 29 December 2018, you failed to provide good clinical care to Patient O in that you:
  - b. diagnosed Patient O with hypogonadism when laboratory evidence did not support a diagnosis of hypogonadism; **Found proved**

437. The Tribunal noted that all the blood tests that the results of which Dr Webberley had available to him, or which had been reported to him, as at the date of his diagnosis and prescription, with the exception of one, were all well within the normal range. The Tribunal accepted Dr Quinton's opinion that these results conclusively excluded any possibility of hypogonadism. The only abnormal result related to a blood test, the report of which was not in the medical records, but which had allegedly been reported by the patient to a non-medically trained facilitator at BMH and then to Dr Webberley during the consultation at BMH. The Tribunal considered that this anomalous result reported by the patient and not supported by a copy laboratory test report was probably unreliable and, in any event, given that the tests in February and March 2018 were unequivocally normal and had been performed prior to a prescription for testosterone gel by the 'WellMan Clinic' (a previous treatment provider), the Tribunal concluded that the diagnosis of hypogonadism was not supported by the laboratory evidence.

438. Accordingly, the Tribunal found paragraph 59b of the Allegation proved.

Paragraph 59c of the Allegation

59. Between 15 May 2018 and 29 December 2018, you failed to provide good clinical care to Patient O in that you:

- c. did not perform any physical or mental health examination of Patient O; **Found not proved**

439. The Tribunal determined that, in the case of Patient O, there was no evidence of any feature present that would have necessarily required a need for Dr Webberley to have performed a physical or mental health examination on Patient O.

440. Accordingly, the Tribunal found paragraph 59c of the Allegation not proved.

Paragraph 59d of the Allegation

59. Between 15 May 2018 and 29 December 2018, you failed to provide good clinical care to Patient O in that you:

- d. did not conduct / arrange a full blood count before prescribing medication to Patient O; **Found proved**

441. BMH's medical record in respect of Patient O appeared to be complete and, in particular, had a separate record of blood tests carried out on various dates between February 2018 and September 2018. Patient O first contacted BMH in early May 2018 and it is documented within the notes that blood tests performed in February and March 2018 had not been obtained by BMH and, in any event, none of the previous or subsequent blood tests included a full blood count.

442. Accordingly, the Tribunal determined that paragraph 59d of the Allegation was proved because it accepted the evidence of Dr Quinton that such tests should have been performed as a baseline prior to treatment.

Paragraphs 59ei, ii and iii of the Allegation

59. Between 15 May 2018 and 29 December 2018, you failed to provide good clinical care to Patient O in that you:

- e. prescribed testosterone, anastrozole, mesterolone and tamoxifen which was:
  - i. not clinically indicated; **Found proved**
  - ii. unsafe; **Found proved**

- iii. not recognised as therapeutic practice in medicine;  
**Found proved**

443. The Tribunal accepted that, in the absence of an appropriate diagnosis of hypogonadism, the prescription of testosterone at any level was not clinically indicated, much less at a dosage that was almost double the appropriate dose frequency for a man with hypogonadism. Furthermore, the Tribunal accepted the evidence of Dr Quinton that the combination of testosterone with the other prescribed drugs did not have any role in the treatment of male hypogonadism in any circumstances and, the treatment regime prescribed was wholly inappropriate and better characterised as a regimen devised for body builders. Such a prescription was unsafe and not recognised as therapeutic practice in medicine.

444. Accordingly, the Tribunal found paragraphs 59ei, ii and iii of the Allegation proved.

#### Paragraphs 59fi and ii of the Allegation

- 59. Between 15 May 2018 and 29 December 2018, you failed to provide good clinical care to Patient O in that you:
  - f. did not make the necessary changes to Patient O's medication when he started to exhibit symptoms associated with over-prescribing of testosterone in that you:
    - i. failed to reduce Patient O's testosterone medication far enough; **Found proved**
    - ii. escalated the dosage of oestrogen blockers;  
**Found proved**

445. The medical record demonstrated that Patient O reported symptoms associated with the over prescription of testosterone; nipple pain and fluid retention. In response to these reported symptoms Dr Webberley did not reduce and/or stop the prescription of testosterone, as Dr Quinton opined, Dr Webberley should have done. Rather, he advised Patient O to commence taking aromatase inhibitors (anastrozole), in this context 'an oestrogen blocker', which had previously been prescribed with a direction not to take unless instructed. This was to address the symptoms of nipple pain/fluid retention without addressing the underlying cause which was excessive testosterone. The Tribunal noted that within a short period after this blood tests, the medical record demonstrated that Patient O had testosterone level of 105 nmols/L, which Dr Quinton described as being 'vastly supraphysiological levels of testosterone'.

446. Accordingly, the Tribunal found paragraphs 59fi and ii of the Allegation proved.

#### Paragraph 59g of the Allegation

59. Between 15 May 2018 and 29 December 2018, you failed to provide good clinical care to Patient O in that you:

- g. did not adequately communicate with Patient O in that you failed to maintain regular correspondence; **Found proved**

447. The Tribunal considered that BMH's medical record in relation to Patient O appeared complete. It acknowledged that there was evidence of direct communication as between Dr Webberley and Patient O via email in May and June 2018. However, the Tribunal noted that following the blood tests received in July 2018 showing 'vastly supraphysiological levels of testosterone' (over three times the upper limit of the normal range), Dr Webberley should have taken action and directly communicated with his patient. The medical records demonstrated that he did not. Rather, he communicated with one of BMH's non-medically trained members of staff recommending an alteration in his prescription. Thereafter, Dr Webberley again altered Patient O's prescription in August 2018 to address ongoing symptoms of excessive testosterone use without communicating with his patient at all. On the basis of Dr Quinton's evidence, the Tribunal concluded that Dr Webberley was treating symptoms of excessive testosterone without addressing the underlying cause and without communicating with his patient.

448. Accordingly, the Tribunal found paragraph 59g of the Allegation proved.

#### Paragraph 59h of the Allegation

59. Between 15 May 2018 and 29 December 2018, you failed to provide good clinical care to Patient O in that you:

- h. did not maintain adequate medical records throughout the period of treatment of Patient O; **Found not proved**

449. The Tribunal noted that the medical record did document, to a degree, Dr Webberley's assessment, care and treatment of Patient O and his decision making. The Tribunal, in the light of its previous findings, considered that Dr Webberley's assessment, care and treatment and decision making in respect of Patient O was inadequate. The Tribunal, however, were not satisfied, on the balance of probabilities, that the medical record itself was inadequate insofar as it did set out what Dr Webberley had done.

450. Accordingly, the Tribunal found paragraph 59h of the Allegation not proved.

#### Paragraphs 59i(i)1 and 2 of the Allegation

59. Between 15 May 2018 and 29 December 2018, you failed to provide good clinical care to Patient O in that you:

- i. did not obtain informed consent from Patient O in that:

- i. the information provided to Patient O before treatment was:
  - 1. inaccurate; **Found not proved**
  - 2. misleading; **Found not proved**

451. The Tribunal had regard to Dr Quinton's criticism of the 'Participation agreement and informed consent' form which contained 'several problematic and controversial statement buried within the text'. However, Dr Quinton did not specify with any particularity why, in his opinion, the form was inaccurate and/or misleading. The Tribunal itself considered the document and regarded it generally as obscure, unhelpful, and relatively meaningless. However, it was unable to identify any aspect of the information as being either inaccurate and/or misleading.

452. Accordingly, the Tribunal found paragraphs 59i(i)1 and 2 of the Allegation not proved.

#### Paragraphs 59i(ii)1 and 2 of the Allegation

59. Between 15 May 2018 and 29 December 2018, you failed to provide good clinical care to Patient O in that you:

- i. did not obtain informed consent from Patient O in that:
  - ii. the Consent Forms for:
    - 1. the treatment plan was not counter-signed by Patient O; **Found not proved**
    - 2. electronic communication was not signed by either yourself or Patient O. **Found not proved**

453. The Tribunal did not consider that the absence of a signature from either the patient, or the doctor, was necessary in order for a patient to give informed consent as the Tribunal have already determined in relation to other patients.

454. Accordingly, the Tribunal found paragraphs 59i(ii)1 and 2 of the Allegation not proved.

#### Patient P

455. In respect of this patient, the Tribunal had no medical records, but it did have direct evidence from Patient P.

#### Paragraph 60a of the Allegation

60. In September 2018, you failed to provide good clinical care to Patient P in that you:

- a. did not hold a consultation with Patient P; **Found proved**

456. For the reasons given in respect of Patient A at paragraph 1a, the Tribunal determined that Dr Webberley should have had a consultation with Patient P. Patient P confirmed in his witness statement that he never spoke to, much less saw, any doctor whilst a patient at BMH.

457. Accordingly, the Tribunal found paragraph 60a of the Allegation proved.

#### Paragraphs 60bi, ii and iii of the Allegation

60. In September 2018, you failed to provide good clinical care to Patient P in that you:

- b. did not elicit an adequate medical history from Patient P, in that you did not elicit details of:
  - i. sexual symptoms; **Found proved**
  - ii. non-sexual symptoms; **Found proved**
  - iii. answers to general systems-orientated questions; **Found proved**

458. Beyond speaking to a call handler at BMH who confirmed that they were not a GP and who asked 'a number of medical questions', Patient P confirmed that he had not spoken to Dr Webberley, or any doctor, whilst a patient at BMH. The Tribunal determined that no medical history had been obtained from Patient P by Dr Webberley who was the prescribing doctor.

459. Accordingly, the Tribunal found paragraphs 60bi, ii and iii of the Allegation proved.

#### Paragraph 60c of the Allegation

60. In September 2018, you failed to provide good clinical care to Patient P in that you:

- c. did not perform any physical or mental health examination of Patient P; **Found not proved**

460. For the reasons given in respect of Patient A at paragraph 1a, the Tribunal found paragraph 60c of the Allegation not proved.

#### Paragraphs 60di1, 2 and 3 of the Allegation

60. In September 2018, you failed to provide good clinical care to Patient P in that you:

d. prescribed testosterone, hCG and anastrozole:

i. which was inappropriate in that it was:

1. not clinically indicated; **Found proved**

2. unsafe; **Found proved**

3. not recognised as therapeutic practice in medicine; **Found proved**

461. The Tribunal noted that prior to prescription, Patient P had had two blood tests some months apart. The first from his GP, the second obtained by BMH (although this test was not referenced by Dr Quinton). However, both of these test results showed testosterone levels to be within the normal range, albeit at the lower end of normal. In Dr Quinton's opinion, which the Tribunal accepted, the testosterone prescribed as a consequence of these blood test results was a dose/frequency around 50% greater than typically required by hypogonadal men. Furthermore, Dr Webberley had also prescribed hCG at a markedly sub therapeutic starting dose for someone with genuine hypogonadotropic hypogonadism. As to the anastrozole that was also prescribed, Dr Quinton opined that it had no routine application in the field of male hypogonadism. Dr Quinton described the overall prescribed treatment regime as one that was not recognised within mainstream endocrinology and characterised it as a 'body builder's cocktail'.

462. Accordingly, the Tribunal found paragraphs 60di1, 2 and 3 of the Allegation proved.

#### Paragraph 60dii of the Allegation

60. In September 2018, you failed to provide good clinical care to Patient P in that you:

d. prescribed testosterone, hCG and anastrozole:

ii. without explaining the risks and benefits to Patient P;  
**Found proved**

463. Patient P's evidence was that he had never spoken to Dr Webberley and as such, the Tribunal inferred that Dr Webberley did not at any stage explain the risks and benefits of the proposed treatment as he should have done in his capacity as the prescribing doctor. For the avoidance of doubt, the Tribunal did not consider that a letter setting out a 'Consent to Treatment Plan' stating, *"this letter should serve as validation of your prescription along with the pharmacy labelled boxes with the prescription instruction from the packaging leaflet"*, was in any way a sufficient explanation of the risks and benefits of the proposed treatment.

464. Accordingly, the Tribunal found paragraph 60dii of the Allegation proved.

Paragraph 60e of the Allegation

60. In September 2018, you failed to provide good clinical care to Patient P in that you:

- e. did not conduct / arrange all necessary tests before prescribing medication to Patient P; **Found not proved**

465. The Tribunal noted that Dr Quinton, in expressing his opinions in relation to this patient, had not had regard to blood test results which had been obtained by BMH in September 2018 and were exhibited to Patient P's witness statement. In circumstances where Dr Quinton had not apparently considered these test results, the Tribunal was unable to determine their adequacy, although the Tribunal did observe that the blood test results included not only testosterone levels but also a full blood count.

466. Accordingly, the Tribunal found paragraph 60e of the Allegation not proved.

Paragraph 60f of the Allegation

60. In September 2018, you failed to provide good clinical care to Patient P in that you:

- f. did not review Patient P's treatment plan; **Found not proved**

467. In the light of a complete absence of any medical records from BMH, the Tribunal was unable to determine whether Dr Webberley had at any stage reviewed Patient P's treatment plan.

468. Accordingly, the Tribunal found paragraph 60f of the Allegation not proved.

Paragraph 60g of the Allegation

60. In September 2018, you failed to provide good clinical care to Patient P in that you:

- g. did not communicate at all with Patient P during the course of his treatment; **Found proved**

469. The Tribunal accepted the evidence of Patient P that, at no stage, was there any communication with Dr Webberley which there should have been given that he was the prescribing doctor.

470. Accordingly, the Tribunal found paragraph 60g of the Allegation proved.

Paragraph 60 of the Allegation

60. In September 2018, you failed to provide good clinical care to Patient P in that you:

h. did not provide adequate follow up care; **Found not proved**

471. Given that Patient P did not, in the event, decide to take the drugs prescribed to him or to continue to seek care from BMH, the Tribunal was unclear as to what adequate follow up care might have been expected. Furthermore, in the absence of any medical records from BMH in respect of Patient P, the Tribunal was not satisfied that this allegation was proved.

472. Accordingly, the Tribunal found paragraph 60h of the Allegation not proved.

#### Paragraph 60i of the Allegation

60. In September 2018, you failed to provide good clinical care to Patient P in that you:

i. did not maintain adequate medical records throughout the period of treatment of Patient P. **Found not proved**

473. In the absence of BMH's medical records having been obtained in respect of Patient P, the Tribunal was unable to determine whether any medical records maintained were adequate or not.

474. Accordingly, the Tribunal found paragraph 60i of the Allegation not proved.

#### **Patient Q**

475. In respect of this patient, the Tribunal had direct evidence from Patient Q, and a contact note from MHC relating to Patient Q.

#### Paragraph 61 of the Allegation

61. In November 2018, you failed to provide good clinical care to Patient Q in that you:

a. did not hold a consultation with Patient Q; **Found proved**

476. In relation to this patient, the Tribunal noted that the evidence was confined to direct evidence from Patient Q together with a single 'Consent to Treatment Plan' dated 12 November 2018, and a patient note obtained from MHC who provided care to Patient Q after he ceased to be a patient with BMH.

477. Patient Q was seeking testosterone treatment for what was said to be a testosterone deficiency, and for the reasons given in respect of other treatments, Dr Webberley should have had a consultation with Patient Q. Patient Q confirmed there was no such consultation.

478. Accordingly, the Tribunal found paragraph 61a of the Allegation proved.

Paragraphs 61bi, ii and iii of the Allegation

61. In November 2018, you failed to provide good clinical care to Patient Q in that you:
- b. did not elicit an adequate medical history from Patient Q, in that you did not elicit details of:
    - i. sexual symptoms; **Found proved**
    - ii. non-sexual symptoms; **Found proved**
    - iii. answers to general health questions concerning the presenting complaint; **Found proved**

479. There was no consultation and Patient Q confirmed that he never had any contact with Dr Webberley, beyond receiving a letter regarding consent to treatment. Patient Q did however confirm that he completed an online questionnaire, which the Tribunal inferred (as it did not have a copy) would have been in the same form as was being used by BMH in relation to other patients at that time. The Tribunal further inferred that reliance upon such a questionnaire alone without investigating 'drilling down' into answers given would have meant that an adequate medical history could not have been elicited from Patient Q, as the Tribunal had already observed, should have happened prior to diagnosis and prescription.

480. Accordingly, the Tribunal found paragraphs 61bi, ii and iii of the Allegation proved.

Paragraph 61c of the Allegation

61. In November 2018, you failed to provide good clinical care to Patient Q in that you:
- c. did not perform any physical or mental health examination of Patient Q; **Found not proved**

481. For the same reasons as set out in relation to Patient A at paragraph 1c, the Tribunal found paragraph 61c of the Allegation not proved.

482. Accordingly, the Tribunal found paragraph 61c of the Allegation not proved.

Paragraphs 61di1, 2 and 3 of the Allegation

61. In November 2018, you failed to provide good clinical care to Patient Q in that you:

- d. prescribed testosterone and anastrozole:
  - i. which was inappropriate in that it was:
    - 1. not clinically indicated;  
**Found not proved in relation to testosterone**  
**Found proved in relation to anastrozole**
    - 2. unsafe;  
**Found not proved in relation to testosterone**  
**Found proved in relation to anastrozole**
    - 3. not recognised as therapeutic practice in medicine;  
**Found not proved in relation to testosterone**  
**Found proved in relation to anastrozole**

483. The Tribunal noted that Patient Q, prior to going to BMH had had blood tests, he had been informed that he had low testosterone and, in due course, received treatment by way of testosterone prescription from a practice in Harley Street, London. As a result of a cost of this treatment Patient Q decided to go to BMH for treatment. The Tribunal also noted the complete absence of any medical records from BMH and the fact that Patient Q, in his witness statement, was not specific as to whether he did or did not have any blood tests whilst a patient of BMH. In these circumstances, the Tribunal found paragraph di1, 2 and 3 not proved with regard to testosterone.

484. However, the Tribunal accepted the evidence of Dr Quinton that even had there been medical records, it was inconceivable that anastrozole would have been clinically indicated. Anastrozole is a drug licenced for treatment of breast cancer and it has no routine application in the field of male hypogonadism although it is known to be used by men who are abusing excessively high doses of testosterone.

485. Accordingly, the Tribunal found paragraphs 61di1, 2 and 3 of the Allegation not proved in relation to testosterone. It found 61di1, 2 and 3 of the Allegation proved in relation to anastrozole.

#### Paragraph 61dii of the Allegation

- 61. In November 2018, you failed to provide good clinical care to Patient Q in that you:
  - ii. without explaining the risks and benefits to Patient Q;  
**Found not proved**

486. Given the absence of medical records and the fact that Patient Q did not specifically deal with the issue in his witness statement, the Tribunal was unable to

determine whether the risks and/or benefits of either drug were explained to Patient Q.

487. Accordingly, the Tribunal found paragraph 61dii of the Allegation not proved.

Paragraph 61e of the Allegation

61. In November 2018, you failed to provide good clinical care to Patient Q in that you:
- e. did not conduct / arrange all necessary tests before prescribing medication to Patient Q; **Found not proved**

488. Given the absence of medical records from BMH and the fact Patient Q does not specifically deal with this issue in his witness statement, the Tribunal found paragraph 61e not proved.

Paragraph 61f of the Allegation

61. In November 2018, you failed to provide good clinical care to Patient Q in that you:
- f. did not adequately communicate with Patient Q in that you delegated communications to non-medically trained members of staff when it was inappropriate to do so; **Found proved**

489. The Tribunal accepted Patient Q's evidence that he had never spoken to Dr Webberley and his only communication from him was letter concerning consent to treatment. The Tribunal determined that in relation to this treatment Dr Webberley, as the prescribing doctor, should have been communicating with his patient, he was not. Patient Q's only contact was with non-medically trained members of staff, a member of whom, on one occasion, gave Patient Q 'an opportunity' to speak to Dr Gary Tudor, who appeared to be another medical practitioner working at BMH.

490. Accordingly, the Tribunal found paragraph 61f of the Allegation proved.

Paragraph 6g of the Allegation

61. In November 2018, you failed to provide good clinical care to Patient Q in that you:
- g. did not review Patient Q's treatment plan; **Found not proved**

491. The Tribunal found this paragraph not proved due to the complete absence of any medical record.

492. Accordingly, the Tribunal found paragraph 61g of the Allegation not proved.

Paragraph 61h of the Allegation

61. In November 2018, you failed to provide good clinical care to Patient Q in that you:

h. did not provide adequate follow up care; **Found proved**

493. The Tribunal noted that Patient Q stated that this included his treatment plan being discussed and changed following a conversation with one of the assistants at BMH. Patient Q categorically stated that the change, involving a switch from testosterone cream to intra-muscular injections was not discussed with Dr Webberley. The Tribunal considered this was inadequate follow up care.

494. Accordingly, the Tribunal found paragraph 61h of the Allegation proved.

#### Paragraph 61i of the Allegation

61. In November 2018, you failed to provide good clinical care to Patient Q in that you:

i. did not maintain adequate medical records throughout the period of treatment of Patient Q. **Found not proved**

495. The Tribunal found this paragraph not proved due to the complete absence of any medical record.

496. Accordingly, the Tribunal found paragraph 61i of the Allegation not proved.

#### Patient R

497. In respect of this patient, the Tribunal had direct evidence from Patient R, and patient contact notes from MHC relating to Patient R.

#### Paragraphs 62a, bi, ii and iii, c, di1, 2 and 3, dii, e, f, g and h of the Allegation

62. Between November 2018 and March 2019, you failed to provide good clinical care to Patient R in that you:

a. did not hold a face-to-face consultation with Patient R; **Found not proved**

b. did not elicit an adequate medical history from Patient R, in that you did not elicit details of:

i. sexual symptoms; **Found not proved**

ii. non-sexual symptoms; **Found not proved**

iii. answers to general health questions concerning the presenting complaint; **Found not proved**

- c. did not perform any physical / mental state examination of Patient R; **Found not proved**
- d. prescribed testosterone, hCG and anastrozole:
  - i. which was inappropriate in that it was:
    - 1. not clinically indicated; **Found not proved**
    - 2. unsafe; **Found not proved**
    - 3. not recognised as therapeutic practice in medicine; **Found not proved**
  - ii. without explaining the risks and benefits to Patient R; **Found not proved**
- e. did not conduct / arrange all necessary tests before prescribing medication to Patient R; **Found not proved**
- f. did not review Patient R's treatment plan; **Found not proved**
- g. did not provide adequate follow up care; **Found not proved**
- h. did not maintain adequate medical records throughout the period of treatment of Patient R. **Found not proved**

498. All of the allegations made in relation to Patient R were advanced by the GMC on the premise that it was Dr Webberley who was responsible for the care of Patient R and, in particular, the prescription of testosterone. The Tribunal acknowledged that Patient R referred in his evidence to being told that a telephone consultation would be arranged with Dr Webberley by a member of staff at BMH. He went on to describe eventually speaking to Dr Webberley on the telephone and his treatment plan being outlined. This was the full extent of what Patient R said was his dealings with Dr Webberley and it was apparent that Patient R never met Dr Webberley. However, the documents produced by Patient R in relation to his treatment from BMH made no reference to Dr Webberley, rather they refer to a doctor whose name has been redacted to Dr GT. In particular, there was a Consent to Treatment Plan, dated 29 November 2018, and signed by Dr GT and Patient R, respectively, on 30 November and 1 December 2018. Within the letter were details of the medication that Dr GT proposed to prescribe to Patient R. The Tribunal noted from the evidence in relation to another patient that, at around this time, there was a 'Dr Gary Tudor' apparently working for BMH, this would be consistent with the redacted name 'Dr GT'. Significantly, Patient R did not comment upon the fact that Dr GT had signed the consent to treatment plan/prescription.

499. In these circumstances, considering the evidence overall, the Tribunal was not satisfied, on the balance of probabilities, that it was in fact Dr Webberley who was responsible for either the care of Patient R or the prescription of drugs to him.

500. Accordingly, the Tribunal found paragraph 62a, bi, ii and iii, c, di1, 2 and 3, dii, e, f, g and h of the Allegation not proved.

Paragraphs 63ai, ii, iii, iv1 and 2 and 63v of the Allegation

63. The treatment to the patients as set out at paragraphs 1 - 62 above was:

- a. provided:
  - i. outside the limits of your expertise as a consultant gastroenterologist; **Found proved**
  - ii. whilst failing to adhere to national and international guidelines; **Found not proved**
  - iii. without the necessary qualifications, training and experience; **Found proved**
  - iv. whilst exposing them to risks of:
    1. androgen toxicity, including: **Found proved**
    2. testosterone-induced erythrocytosis; **Found proved**
  - v. knowing or believing that it was to be used by the patients for reasons not based on any clinical need; **Found proved**

501. The Tribunal had regard to Good Medical Practice 2016 ('GMP'), in particular, paragraph 14, which states:

***"Apply knowledge and experience to practice***

*14. You must recognise and work within the limits of your competence."*

502. The Tribunal considered the evidence available to it as to Dr Webberley's expertise during the relevant period, namely, from April 2017 to the end of 2018.

503. In relation to 63ai and iii, the Tribunal concluded that Dr Webberley was under a duty not to work outside the limits of his expertise, or without the necessary qualifications and training in the field in which he was purporting to practice. The Tribunal accepted, and the GMC did not suggest otherwise, that Dr Webberley had expertise, qualification, training and experience as a consultant gastroenterologist (albeit retired at the relevant time). However, the Tribunal did not

have any evidence that Dr Webberley had undergone training or qualification in endocrinology, particularly in relation to hormone deficiency syndromes. In this regard, the Tribunal considered Dr Webberley's CV which was undated but appeared to have been drafted no earlier than 2018, with CPD records and appraisal documentation, dated in November 2017. The appraisal document included the appraiser's summary in relation to Dr Webberley's practice at that time:

*"Dr Webberley retired from NHS work in June 2016 where he was working as a Consultant Gastroenterology. He now works as a Locum Physician in a Transgender Medical Clinic and also a prescriber for an online pharmacy. Dr Webberley is a very accomplished clinician and medical manager and has contributed extraordinarily to the wider cause of NHS in Wales. I am pleased to know that he has made an uneventful recovery from his recent knee surgery. It was impressive to hear and feel Dr Webberley's enthusiasm towards less developed area of medicine where the transgender population is not served well.*

*Dr Webberley will continue to develop his interest in hypogonadal adult males and the adenopause."*

504. In the Tribunal's judgement, whilst it noted that Dr Webberley would be continuing to 'develop' an interest in the treatment of hypogonadal adult males, this summary fell far short of demonstrating expertise, qualification, training or experience in the treatment of hypogonadal men.

505. In these circumstances, the Tribunal concluded that Dr Webberley was providing treatment outside the limits of his expertise, qualification, training and experience.

506. Furthermore, by virtue of the Tribunal's findings in relation to Patients A to R, a cohort of patients treated in respect of male hypogonadism, the Tribunal considered that the extensive failings which it had found proved supported the conclusion that during the relevant period, and in respect of these patients, Dr Webberley was providing treatment outside the limits of his expertise, qualification, training and experience.

507. Accordingly, the Tribunal found paragraphs 63ai and iii of the Allegation proved.

508. In relation to paragraph 63aii, in support of Dr Quinton's opinion with regard to the appropriate treatment of patients for male hypogonadism, he referenced in his evidence, 'The Society for Endocrinology Guidelines for Testosterone Replacement Therapy in Male Hypogonadism (2021)'.

509. The Tribunal was wholly satisfied that in numerous respects the treatment provided by Dr Webberley to Patients A to R was not in accordance with recognised medical practice for the treatment of male hypogonadism. The Tribunal, in these circumstances, suspected that the treatment provided to these patients did not adhere to national and international guidelines current at the relevant time. Indeed,

Dr Quinton asserted in his report that, in his opinion, Dr Webberley had failed to treat patients in accordance with national and international guidelines. However, the Tribunal noted that the only guidelines to which Dr Quinton had made specific reference were those referenced above, and which were published in 2021. Therefore, they could not have been guidelines Dr Webberley would have been required to adhere to in respect of these patients. For this reason, and for this reason alone, the Tribunal found paragraph 63a<sup>ii</sup> of the Allegation not proved.

510. In relation to paragraphs 63a<sup>iii</sup>1 and 2, the Tribunal accepted Dr Quinton's evidence, which was repeated and consistent throughout, that the administration of exogenous testosterone exposes the patient to a risk of androgen toxicity which included testosterone induced erythrocytosis. Therefore, the Tribunal found paragraphs 63a<sup>iii</sup>1 and 2 of the Allegation proved.

511. In relation to paragraph 63a<sup>v</sup>, the Tribunal determined that Dr Webberley's misdiagnosis of, and treatment for, male hypogonadism in respect of Patients A to R, was not simply as a result of incompetence borne of a lack of expertise, qualification, training and or experience. Rather, it was done knowing or believing that the treatment was neither clinically indicated nor necessary. For the reasons previously referred to in respect of the Tribunal's findings as to paragraph 3a, Dr Webberley must have known that the pre-diagnostic blood tests that he was receiving in respect of these patients were consistently within the normal range and therefore against a diagnosis of male hypogonadism. Furthermore, on numerous occasions, not only was Dr Webberley prescribing treatment regimens that had no recognised medical application for the treatment of hypogonadism, and which were characteristic of those sought by 'body builders', the patients themselves were invariably indicating a desire or preference to be prescribed these treatment regimens before Dr Webberley had made any diagnosis. In the Tribunal's judgement, Dr Webberley's conduct in this regard was entirely consistent with his knowing or believing that his patients were seeking the prescriptions for reasons other than clinical need.

512. Accordingly, the Tribunal found paragraph 63a<sup>v</sup> of the Allegation proved.

#### Paragraph 63b of the Allegation

63. The treatment to the patients as set out at paragraphs 1 - 62 above was:

b. financially motivated. **Found proved**

513. From the evidence before the Tribunal, it was apparent these patients were paying privately for treatment. BMH's business in respect of the treatment of these patients was an entirely private enterprise, as was plain from the contractual documentation produced in respect of them. Secondly, there was evidence that Dr Webberley was providing a professional service to BMH for a fee. Dr Webberley, a retired consultant gastroenterologist, was engaged by BMH to provide a service to BMH's clients for which he was remunerated. In these circumstances, and in the absence of any other reasonably conceivable explanation, the Tribunal concluded

that Dr Webberley did have a financial motivation in the provision of treatment to these patients.

514. Accordingly, the Tribunal found paragraph 63b of the Allegation proved

### **Transgender Patients**

#### **The Medicine and Science Behind Gender Dysphoria and Transitioning**

515. Before analysing the evidence in relation to these patients it was necessary to give a summary of gender dysphoria, its diagnosis and treatment.

#### **The diagnostic approach to the treatment of 'Gender Dysphoria'.**

516. The 'Diagnostic and Statistical Manual of Mental Disorders [DSM-5]' (2013) provided for one overarching diagnosis of gender dysphoria, with separate specific criteria for children, for adolescents, and for adults:

“In adolescents and adults gender dysphoria diagnosis involves a difference between one’s experienced gender and assigned gender, and significant distress or problems functioning. It lasts at least six months and is shown by at least two of the following:

1. A marked incongruence between one’s experienced / expressed gender and primary and / or secondary sex characteristics
2. A strong desire to be rid of one’s primary and / or secondary sex characteristics
3. A strong desire for the primary and / or secondary sex characteristics of the other gender
4. A strong desire to be of the other gender
5. A strong desire to be treated as the other gender
6. A strong conviction that one has the typical feelings and reactions of the other gender.

517. In relation to children, DSM-5 states that gender dysphoria diagnosis involves at least six of the following and an associated significant distress or impairment in function, lasting at least six months:

1. A strong desire to be of the other gender or an insistence that one is the other gender.
2. A strong preference for wearing clothes typical of the other gender

3. A strong preference for cross-gender roles in make-believe play or fantasy play.
4. A strong preference for toys, games or activities stereotypically used or engaged in by the other gender.
5. A strong preference for playmates of the other gender.
6. A strong rejection of toys, games and activities typical of one's assigned gender.
7. A strong dislike of one's sexual anatomy.
8. A strong desire for the physical sex characteristics that match one's experienced gender."

518. Gender dysphoria is classified as a formal diagnosis, which is a pre-condition for medical treatment to be commenced. It is not an *illness*, but rather a psychological condition that often requires medical intervention. In the context of this case it is particularly important to emphasise that gender dysphoria does not always require treatment, as some transgender persons live their lives in their transitioned identity without seeking any medical treatment or interventions.

519. For those that require treatment, gender transitioning is generally accepted to be the process of changing one's gender presentation, or sex characteristics, to accord with one's innate sense of gender identity – the idea of what it means to be a man or a woman, or to be non-binary or genderqueer.

### The Treatment of Gender Dysphoria in Children and Adolescents

520. There are three distinct phases intended to help a patient in achieving their transitioning to their desired gender identity:

- a. Stage 1 is the administration of a Gonadotropin-releasing hormone analogue [GnRHa] (a form of 'puberty blocker'). This is clinically appropriate for children and young people who have reached Tanner Stage 2 (or above) of puberty development. Tanner Stage 2 marks the beginning of the physical development of puberty. In natal girls, this is the start of development of the breasts and in natal boys, the testicles and scrotum begin to get larger.

GnRH is a hormone secreted as pulses spaced around 2 hours apart by specialised neurons in the Hypothalamus, directly into the blood supply of the Pituitary gland. Responding to these GnRH pulses, the pituitary secretes two glycoprotein hormones, LH and FSH, which stimulate the gonads (testes or ovaries) to secrete sex hormones (testosterone, or oestrogen+progesterone) and produce gametes (sperm or eggs).

GnRHa has been described as the ‘pilot light’ of reproduction, with the onset of secretory activity first observed during the final trimester of fetal development and continuing for 4-6 months postnatally. Thereafter, GnRH neuronal networks become quiescent during childhood, with their secretory re-awakening in adolescence signalling the onset of puberty.

Crucially, pulsatility of the GnRH signal is an absolute prerequisite for pituitary responsiveness. When presented with a continuous GnRH infusion or a long-acting GnRH-agonist (GnRHa), pituitary responsiveness down-regulates within days, resulting in paradoxical blockade of LH and FSH secretion and thus complete suppression of gonadal steroid secretion. Thus, arresting pubertal development.

Licensed applications of GnRHa in the UK and elsewhere relate to the treatment of androgen-responsive prostate cancer in men and of endometriosis in women. However, GnRHa are also widely used off-label (but with a good evidence base) in the UK as an adjunct to cross-hormone therapy in the treatment of transgender clients; principally in trans-women who have not achieved adequate suppression of testosterone levels, but also trans-men in whom menstruation persists.

However, GnRHa hormones are also used ‘*off-label*’ to arrest puberty in children and adolescents in whom puberty has begun at an abnormally early age (gonadotrophin-dependent precocious puberty).

Over the past decade – in a protocol pioneered in Amsterdam and then adopted by the Tavistock (Gender Identity & Development Service) – GnRHa have also been administered to minors presenting with gender dysphoria during puberty, so as to ‘stop the puberty clock’ and give them 1 to 2 years’ ‘breathing space’ or ‘thinking time’. At the end of this period, they can either begin cross-hormone therapy in order to complete transition, or discontinue treatment and allow resumption of normal puberty in their birth gender.

- b. Stage 2 of the treatment is the administration of cross-sex hormones (CSH) [gender affirming hormone treatment] which (generally) can only be prescribed from around the age of 16.
- c. Stage 3 is gender reassignment surgery, which is only available via adult services to people aged over 18.

521. It is important to note that these three phases are separate and distinct, and it does not necessarily follow that an individual commences on Stage 1, that they will thereafter progress to Stage 2 or thereafter Stage 3.

### **The Management and Treatment of Adults with Gender Dysphoria**

522. In the opinion of Dr Quinton this is a significantly more mainstream area of practice than it is in minors and the hormone management also differs in a number of respects.

523. First, having already experienced life as a reproductively mature adult in their birth gender, their dysphoria necessarily has a more objective dimension based on real-life experiences and the diagnosis is therefore more straightforward than in minors. Second, because final adult height and completion of puberty in birth gender have already been achieved;

(i) clinicians can have far greater certainty that there is no underlying Disorder of Sexual Development (DSD) i.e a genetic or chromosomal condition that presents with a neonatal genital ambiguity or disorder of puberty, and characterised by an abnormality of gonadal development, hormone secretion or hormonal action.

(ii) first-line drug treatment can be initiated with cross-sex hormones rather than GnRH<sub>a</sub>.

524. GnRH<sub>a</sub> are reserved as second-line adjuvant treatment for transgender adults experiencing symptoms related to inadequate suppression of endogenous hormones despite cross-sex hormone treatment; e.g. menstrual bleeding or pelvic cramps (despite testosterone treatment) in a client of female birth gender, or persistent and unwanted facial or body hair growth, or penile erections (despite oestrogen treatment) in a client of male birth gender.

525. However, as with children and adolescents before initiating cross-sex hormone treatment, several issues should be considered:

- Gender incongruence should have been diagnosed following an appropriate assessment by an appropriately qualified specialist usually working within an MDT.
- A careful assessment of risk versus benefit in relation to cross-hormone treatment should have been undertaken, preferably a specialist familiar with the prescription of hormones.
- Although cross hormone-induced biological transition to the gender-of-identification has the potential to improve symptoms of low mood or anxiety arising from gender dysphoria, such hormone treatment cannot be a panacea for psychological symptoms in general.
- Where there is a significant mental health diagnosis – evidence for which may arise from review of case records or comprehensive mental state examination (MSE) performed by a member of the Gender specialist team – consideration must be given to whether there is an impairment or disturbance of the functioning of mind or brain that is sufficient to affect mental capacity in relation to decision-making.
- After the commencement of cross hormone treatment there needs to be a continuing periodic review and monitoring of the patient's response to treatment.

## Analysis of what amounts to Good Clinical Care in relation to Gender Dysphoria and Transgender Treatment

526. As with the androgen patients, the majority of the allegations in relation to the transgender patients S-Y, related to the failure to provide good clinical care. Accordingly, it was necessary in determining these allegations for the Tribunal to consider the nature and extent of Dr Webberley's duties in relation to this cohort of patients and the care that he was providing them.

527. In this regard the Tribunal was informed by the following publications:

- a. Good Medical Practice (2013) ('GMP') and relevant supplemental guidance;
- b. Standards of Care for the Health of Transsexual, Transgender, and Gender - Nonconforming People - The World Professional Association for Transgender Health (V7 - 2012);
- c. Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society\*Clinical Practice Guideline, J Clin Endocrinol Metab, November 2017;
- d. NHS Standard Contract for gender identity development service for children and adolescents, period 1 April 2016 to 1 April 2020;
- e. Royal College of General Practitioners - Guidelines for the Care of Trans\* Patients in Primary Care (2015);
- f. Guidance for GPs, other clinicians and health professionals on the care of gender variant people. (NHS/Department of Health), dated 10 March 2008;
- g. Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline, Journal of Clinical Endocrinology and Metabolism, dated 1 September 2009;
- e. Statement on the Management of Gender Identity Disorder (GID) in Children & Adolescents, The British Society for Paediatric Endocrinology and Diabetes, dated December 2009;
- F. Good practice guidelines for the assessment and treatment of adults with gender dysphoria, Royal College of Psychiatrists, dated October 2013;
- g. Interim Gender Dysphoria Protocol and Service Guideline 2013/14, NHS England, dated 28 October 2013;
- h. Primary Care responsibilities in relation to the prescribing and monitoring of hormone therapy for patients undergoing or having undergone Gender dysphoria treatments, dated 26 March 2014;
- i. Approach to the Patient: Transgender Youth: Endocrine Considerations, NHS England;
- j. Specialised Services Circular, dated 1 December 2014;

- k. Clinical Commissioning Policy: Prescribing of Cross-sex hormones as part of the Gender Identity Development Service for Children and Adolescents, NHS England, dated 22 August 2016;
- l. Clinical Management of Gender Identity Disorder in Adolescents: A Protocol on Psychological and Paediatric Endocrinology Aspects, European Journal of Endocrinology, 2006;

528. The Tribunal also had regard to the expert opinion evidence of Dr Quinton and Dr Kierans, with regard to the standard of care to be expected of a reasonably competent consultant physician providing care and treatment to gender patients.

**The Tribunal's analysis of the evidence and findings in relation to the transgender patients – Patients S-Y (Paragraphs 64-82 of the Allegation)**

**Patient S**

529. Patient S had been assigned male at birth and was 17 when she made her initial approach to GenderGP on 15 January 2017. At this time Patient S was already involved with Child and Adolescent Mental Health Services ('CAMHS'), under the care of Dr Tasker, she had been diagnosed with an Autistic Spectrum Disorder (ASD) and was seeking a referral to the Tavistock and Portman NHS Trust Gender Identity Disorder Service (GIDS).

530. In considering a medical practitioner's duty to provide good clinical care, both in relation to Patient S and the other transgender patients, the Tribunal was mindful of the fact that the care Dr Webberley was providing was on a private basis and was in circumstances where the patient had sought treatment through the NHS by referral to either the Tavistock Clinic GIDS (a child and adolescent service), or through the Charing Cross Hospital GIDS (an adult service).

531. Further, the Tribunal acknowledged that on the evidence before it, there was a gap in the provision of specialist transgender services within the NHS by reason of demand for services far exceeding the resources available for supply. As a consequence, there was a cohort of patients who may have a real clinical need for assessment and treatment, but who were unable to access the same as a result of lengthy waiting lists. The Tribunal also acknowledged that this issue became all the more acute in respect of children or adolescents who were experiencing gender dysphoria. These patients, who had a clinical need for puberty blockers, needed to start their treatment before puberty was complete, otherwise the purpose of the puberty blockers would be defeated.

532. Additionally, the Tribunal noted that there could be a further difficulty where a young person was aged 16 or 17 and seeking treatment at the Tavistock GIDS, who only treated up to the age of 18, and the length of the waiting list was such that they became ineligible by the time of their first appointment. At this point they would need to be referred to an adult service i.e the Charing Cross GIC, and join their waiting list. This situation could cause a hiatus when the young person could not access treatment from either service.

533. The Tribunal noted that, at the time Patient S made contact online with GenderGP, they were already a patient with the Cwm Taf Health Board CAMHS with regard to their gender identity issues. They had been referred by the CAMHS to the Tavistock GIDS and were awaiting their first appointment. However, due to Patient S's age at the time they contacted GenderGP, there was some lack of clarity within the CAMHS whether they should be continuing with the referral to Tavistock GIDS, or whether Patient S should have been referred to an adult GIC. Dr Tasker's evidence was that at the time Patient S was seeking a private hormone provider and the CAMHS were waiting to refer Patient S to an adult GIC. The Tribunal considered this to be an example of the real difficulties young patients could experience when seeking to access treatment through the NHS.

534. Nonetheless, the Tribunal, whilst recognising that the provision of private transgender care was capable of addressing the absence of adequate provision within the NHS, this did not mean that the standard of care provided should be any less than the patient should be entitled to receive within the NHS. The need to provide timely care to a patient who may be experiencing gender dysphoria could not be a justification for the taking of 'shortcuts' in assessment, diagnosis and treatment.

#### Paragraph 64a of the Allegation

64. Between February 2017 and November 2018, you failed to provide good clinical care to Patient S in that you:
  - a. did not establish an adequate Multi-Disciplinary Team ('MDT'); **Found proved**

535. In relation to this allegation and the identical allegations made in respect of other transgender patients, the Tribunal first considered whether Dr Webberley, in providing good clinical care to Patient S, was under a duty to establish an MDT, or to put it another way, would a failure by Dr Webberley to establish an MDT necessarily amount to a failure to provide good clinical care.

536. As to this issue, the Tribunal noted that the provision of care to transgender patients in the United Kingdom was, in the NHS, delivered through an MDT. The Tribunal considered this to be unsurprising because the treatment and care of transgender patients will necessarily cross different medical disciplines. Furthermore, the public provision of transgender care through the NHS was governed by the 'Interim NHS England Gender Dysphoria Protocol and Guidance 2013/14 – CPAG Approved 12 July 2013', which makes provision for the commissioning of gender identity clinics ('GIC') for the care of gender dysphoric patients. The guidance makes it a requirement that:

- There is an effective multi-disciplinary team (MDT) that meets regularly, either in person or through electronic communication;
- The delivery of patient care is based upon individual care plans that are agreed and reviewed by the provider's multi-disciplinary team;

- A complete range of multi-disciplinary services are offered as provided for by the guidance;
- The MDT meets team member training and quality standards that NHS England determine.

537. This guidance only applied to the provision of transgender care through the NHS and did not apply in relation to the provision of private transgender care. However, the Tribunal also had regard to other guidance and protocols supporting the principle that transgender care should be provided through an MDT.

538. The Royal College of Psychiatrists: Good Practice Guidelines for the Assessment and Treatment of Adults with Gender Dysphoria (2013) recommends:

*“1 The principle of multidisciplinary and interdisciplinary teams and networks who work and collaborate in the provision of services for persons with gender dysphoria is paramount. These services may operate out of different venues and locations and engage in regular governance review.*

*2 A multidisciplinary team or network will have terms of engagement, rules of confidentiality and regular supervision. Patients will be consulted and involved in clinic and network decision-making and policy development.*

*3 The multidisciplinary team will usually act as a focus for a network of clinicians in a region.*

...

*6 Each team should have specific link clinicians and this would cover all disciplines including links with learning disability services, district nursing, etc.”*

539. The guidelines also stated in relation to collaborative working:

*“...Treatment in this field is particularly holistic in the degree to which different specialties may be involved. There is no necessity for specialists to work together under the same roof. Indeed, patients may not experience the full benefits of choice and emergent expertise if their options are constrained in such a fashion. Nevertheless, it is desirable that practitioners should establish protocols for working together.*

*In whatever way the multidisciplinary approach is organised, whether at a gender identity clinic or by a group of health professionals locally, the patient’s choice of service provider should not be unreasonably limited, and delivery must not be unreasonably delayed.”*

540. Specifically in relation to children and adolescents, the guidelines quoted the

‘The British Society for Paediatric Endocrinology and Diabetes’ position statement of 2009, which recommended that:

*“the care of adolescents should be offered within a specialist multidisciplinary team on an individual basis...”*

541. The Tribunal also considered the guidance provided by World Professional Association for Trans Health (‘WPATH’) standards of care for the health of transsexual, transgender and gender/non-conforming people 2012. The guidance appeared to endorse the use of an MDT in relation to the provision of care to adults, children and adolescents. However, equally the guidance appeared to envisage that such care might be provided outwith an MDT but, in such circumstances, it recommended a mental health professional should provide consultation and liaison arrangements with an endocrinologist (paediatric in case of children and adolescents) for the purpose of assessment, education and involvement in any decisions about physical interventions. The Tribunal concluded from this that an endocrinologist could be substituted with a gender specialist physician with the requisite competence, skills and experience in endocrinology (a gender specialist).

542. Similarly, the ‘Guidance for GPs, Other Clinicians and Health Professionals on the Care of Gender Variant People. (NHS/Department of Health)’ states:

*“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. Otherwise referrals may be made to a specialist Gender Identity Clinic (GIC) where there are multidisciplinary teams of professionals. **Private treatment with a gender specialist may be preferred by the service user** [Tribunal emphasis].”*

543. In determining whether an MDT was necessarily required for the provision of transgender care, the Tribunal also had regard to the expert evidence of Dr Quinton, and in particular, Dr Kierans. Both Dr Quinton’s and Dr Kierans’ evidence was given in the context of their knowledge and experience of the extensive provision of transgender care, underlying which, was an assumption that it would necessarily be provided in the context of an MDT environment.

544. Finally, the Tribunal noted that Dr Webberley had himself seemingly recognised and endorsed the use of MDTs in the provision of transgender care by his purported provision of the same by GenderGP in letters sent to GPs and communications with the GMC during the course of the investigation.

545. In these circumstances, the Tribunal concluded that it would always be desirable for transgender care to be provided through an MDT. Further, the Tribunal considered that, some might argue, provision through an MDT would present ‘best practice’. Nevertheless, the Tribunal did not conclude that within the context of private healthcare provision, good clinical care necessarily, and in all cases, required

the establishment of a traditional MDT. However, the Tribunal determined that if transgender care was provided outwith an MDT, it would necessarily require the medical practitioner providing the care to have sufficient specialist knowledge, experience and training in the provision of such care and also the practitioner would need to consult and liaise with other medical professionals for the purpose of assessment, diagnosis, treatment and decision making.

546. The Tribunal determined that, for reasons dealt with elsewhere in this decision, that Dr Webberley lacked sufficient specialist knowledge, experience or training in the provision of transgender care. Accordingly, in practical terms, the only way he could have provided good clinical care was by means of establishing an adequate MDT. The Tribunal next went on to determine, before considering the evidence in relation to any of Dr Webberley's transgender patients, what would constitute an adequate MDT in this context.

547. The Tribunal heard evidence from both the experts and concluded that there were two aspects to this issue. Firstly, what should be the core composition of an MDT and secondly, how should the MDT function in order to be adequate.

548. The evidence of Dr Kierans in relation to the gender identity service (a child and adolescent service) for which she works and has direct experience, the MDT consists of a Specialist Clinical Psychologist (herself), a Clinical Nurse Specialist, and a Consultant Child and Adolescent Psychiatrist and input as required from a Consultant Paediatric Endocrinologist and an Endocrine Nurse Specialist.

549. Dr Quinton gave evidence in relation to the composition of the MDT within the GIDS provided by the Tavistock Clinic as provided by their service contract with NHS England, which specified assessment and treatment being provided by the MDT with contributions from specialist social workers, family therapists, psychiatrists, psychologists, psychotherapists, paediatric and adolescent endocrinologists and others. Additionally, he gave evidence with regard to his own experience working within an adult transgender MDT in the Northeast of England.

550. The Tribunal, having considered the expert evidence and various guidelines and protocols that, whereas it was not possible to be prescriptive as to the composition of an MDT in the context of transgender care, the MDT must, as a bare minimum, include a suitably qualified mental health professional, with specialist knowledge and experience in transgender medicine, and a suitably qualified endocrinologist or gender specialist and, where children or adolescents are concerned, a paediatric mental health professional and a paediatric endocrinologist or a paediatric gender specialist.

551. With regards to the functioning of an MDT, the Tribunal accepted the evidence of Dr Kierans (which was supported by Dr Quinton), and referencing NHS England's Interim Gender Dysphoria Protocol and service Guideline (2013):

*“Professionals operating in isolation cannot be considered a MDT. NHS England's Interim Gender Dysphoria Protocol and service Guideline (2013) for example state that service providers should:*

*Have an effective multidisciplinary 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)."*

552. In the Tribunal's judgement, the requirement for an MDT means, as the name suggested, that there was 'team working' and this would include, but not be limited to; discussion about patients' presentation and assessment, joint treatment planning, joint decision making and joint review. An individual practitioner who, from time to time, utilises the services of another practitioner is neither a functioning nor adequate MDT.

553. The Tribunal next considered the evidence specific to the case of Patient S. In January 2017, Patient S first contacted GenderGP at age 17 and four months, they had been assigned male gender at birth and were seeking oestrogen treatment for gender affirmation as a female, their identified gender. Initially, both Dr HW and Dr Webberley were involved in Patient S's care. However, after 18 February 2017, the evidence showed that it was Dr Webberley alone who was responsible for Patient S's care. GenderGP's medical records in relation to Patient S demonstrated that the other individuals involved in Patient S's care at GenderGP was someone referred to as 'Avril'[Colette], Ms Marianne Oakes, described as a Lead Counsellor at GenderGP and, later, about a year after Dr Webberley had prescribed cross-sex hormone therapy, Ms Jayne Olden, described as Counsellor, Specialising in Couples, Bereavement and Gender Identity. Also, elsewhere within GenderGP documentation from GenderGP she was described as 'Counsellor and psycho/gender therapist'.

554. The Tribunal was unable to discern from the evidence generally or GenderGP's records in particular, what if any, qualification any of these three individuals may have had, or indeed, what if any experience they had in transgender medicine. In particular, the Tribunal had no evidence to suggest that they could not properly be described as 'mental health professionals' as broadly defined by WPATH in respect of those individuals who are qualified in the assessment and diagnosis of gender dysphoria.

555. Even assuming that one or more of these counsellors was appropriately qualified, there was no evidence to suggest that there was any endocrinologist (or gender specialist) involved, or consulted, in relation to Patient S's care. Therefore, the Tribunal concluded that there was no adequate MDT operating in relation to the care of Patient S.

556. Avril [Colette] had conducted what appeared to be some form of a telephone assessment described as 'an information gathering session'. She prepared a report that was reviewed by Ms Oakes. Ms Oakes seemingly endorsed the contents of the report and made some additional observations identifying that some further basic questions required answering. Beyond this, the patient notes did not record any detail of meetings, discussions, joint decision making or planning as between Dr Webberley, Avril [Colette] or Ms Oakes. Indeed, within three days of Ms

Marianne Oakes making her review of Avril [Colette's] report, Dr Webberley recorded:

*“happy to go ahead will need GP to be involved and informed will need ongoing counselling alongside medical transitions”.*

557. There followed email correspondence from Patient S's father regarding the requirement for ongoing counselling. In the event, Dr Webberley agreed that such counselling could be dispensed with provided that Patient S and her father consented. By 24 July 2017 Dr Webberley had prescribed cross-sex hormones to Patient S.

558. Having considered the evidence in relation to the care provided to Patient S, both prior to assessment, diagnosis and prescription and thereafter, the Tribunal concluded that those identified individuals at GenderGP involved in Patient S's care were not working as an MDT (even assuming that they had the qualification and experience to do so). Accordingly, the Tribunal determined that even if it were an 'MDT', which it was not, it was for these reasons that it was not a functioning or adequate MDT.

559. In reaching this conclusion, the Tribunal observed despite there being the involvement of Dr Tasker at CAMHS in relation to Patient S, no contact had been made with either the doctor or CAMHS by GenderGP. The involvement of CAMHS was apparent from Patient S's initial questionnaire submitted to GenderGP. However, it was of note that, notwithstanding this fact, and that attempts were made by the doctor at CAMHS to make contact with Dr Webberley, Dr Webberley failed to respond. The Tribunal also had regard to the fact that Dr Webberley had sent information to Patient S's GP regarding Patient S's care. This was only after Dr Webberley had initiated Patient S's treatment and was for the purpose of seeking to enter into a shared care agreement for the prescription of medication.

560. Accordingly, the Tribunal found paragraph 64a of the Allegation proved.

#### Paragraphs 64bi and ii of the Allegation

64. Between February 2017 and November 2018, you failed to provide good clinical care to Patient S in that you:

b. did not conduct any:

i. physical assessment; **Found proved**

ii. face-to-face or video consultation with Patient S;  
**Found proved**

561. The Tribunal considered that it would always be necessary for the medical practitioner responsible for making clinical decisions to have, at the very least, a face-to-face consultation, either in person or via a video link. This was explicitly the evidence of Dr Quinton. The Tribunal accepted the evidence of Dr Quinton, that a

physician specialising in gender dysphoria would have conducted at least two face-to-face consultations (he acknowledged in oral evidence this could be by video link) before making a diagnosis. The reason for this, as Dr Kierans made clear was that, when a patient was receiving treatment via an MDT, each young person and family are seen by a minimum of two members of an MDT during their assessment period. Additionally, the endocrinology assessment would consist of a range of physical health checks to ensure the young person is physically well and there are no contra indications to treatment. This accorded with the WPATH guidelines which required the assessment topics to include, amongst other things, physical health and wellbeing checks. This would include a detailed exploration of a young person's understanding and consideration of the issues involved.

562. The Tribunal had already found there was in fact no functioning MDT in the case of Patient S. Accordingly, it was Dr Webberley who was making the ultimate decisions in relation to assessment, diagnosis and treatment. In the absence of a functioning MDT, it would have been Dr Webberley's responsibility himself to conduct these assessments, at the very least with a face-to-face consultation or by a video link/skype consultation. This would be so even if the 'counsellors' who spoke to Patient S had themselves had face-to-face consultations, although the evidence suggested they were telephone consultations.

563. Therefore, whether or not counsellors or others had seen the patient, it was incumbent on Dr Webberley himself to thoroughly assess the patient before diagnosing and commencing treatment.

564. Furthermore, GenderGP appeared to acknowledge the need for Dr Webberley to see Patient S in person when Patient S was written to on 19 January 2017, as part of GenderGP service conditions:

*"3) We will need to see you in clinic. This is either in Abergavenny for an hour with Dr Webberley at £150. Alternatively we can offer an appointment with Dr Webberley in London for £200. You may also need to arrange a separate, face-to-face counselling assessment local to you..."*

565. The Tribunal determined that the medical record for Patient S demonstrated that there was no evidence that, at any time during the period Patient S was under the care of Dr Webberley, she had ever spoken to him, much less, had a face-to-face consultation.

566. Accordingly, the Tribunal found paragraphs 64bi and ii of the Allegation proved.

#### Paragraphs 64ci1, 2, 3 and 4 of the Allegation

64. Between February 2017 and November 2018, you failed to provide good clinical care to Patient S in that you:

- c. relied upon an inadequate mental health assessment in that you:

- i. relied entirely upon the opinions of counsellors:
  1. without adequate qualifications;  
**Found not proved**
  2. without registration with a recognised regulatory body; **Found not proved**
  3. who conducted a telephone interview of unknown quality or duration; **Found proved**
  4. who produced a report which you should have recognised was not sufficiently detailed;  
**Found proved**

567. In relation to paragraphs 64ci1 and 2, the Tribunal had regard to the WPATH guidelines, which Dr Webberley had asserted in correspondence that GenderGP followed, regarding the recommended minimum qualifications for mental health professionals involved in the assessment of children and adolescents with gender dysphoria. In terms of formal qualification, WPATH identifies a master's degree or its equivalent in a behavioural science field, together with documented credentials from a relevant licensing board. However, whilst acknowledging mental health professionals are best prepared to conduct assessments of gender dysphoria, WPATH recognise that other health professionals with appropriate training may conduct assessments.

568. In relation to the two counsellors involved in the care of Patient S, Ms Avril Colette and Ms Marianne Oakes, the Tribunal had no evidence as to either the qualifications, or experience of Ms Avril Colette. Ms Marianne Oakes, who was described in a document prepared by Dr Webberley, in which he listed the members of GenderGP's 'Multi-disciplinary Team', as 'Lead Counsellor and lead therapist BACP'. The Tribunal would have expected Ms Oakes' qualifications to have been included within this document if she had relevant qualification. However, the Tribunal did not consider that this was sufficient evidence, on the balance of probabilities, that she did not have relevant qualification. The Tribunal also noted that she was a member of the British Association of Counsellors and Psychotherapists (BACP), a recognised UK regulatory body.

569. Accordingly, the Tribunal found paragraphs 64ci1 and 2 of the Allegation not proved.

570. In relation to paragraph 64ci3, and for the reasons already given as set out in relation to paragraphs 64bi and ii, even if there were a functioning MDT in relation to Patient S, and it had been appropriate for assessments to be conducted by counsellors, and assuming they were adequately qualified mental health professionals, the assessments would have had to have been face-to-face. It would not have been sufficient for the interviews to be conducted by telephone. The only

counsellor Patient S spoke to was Ms Avril Colette and this was on a single occasion, on or about 9 June 2017, and was by telephone.

571. Accordingly, the Tribunal found paragraph 64ci3 of the Allegation proved.

572. In relation to paragraph 64ci4, the report provided by Ms Avril Colette, with the exception of a questionnaire completed prior to the telephone conversation with Ms Colette, and a subsequent clarification email between Ms Oakes and Patient S on 13 June 2017, represented the only source of information for assessment of Patient S.

573. The Tribunal, even in the absence of expert evidence would have concluded, given its purpose, that the report was superficial and lacking in essential detail. However, this was also a view confirmed by Dr Kierans. She identified numerous and significant inadequacies of the report and described it as representing only the beginning of the information gathering required to consider treatment for gender dysphoria; there was no exploration as to why Patient S had delayed seeking treatment (she had stated she had known she was transgender since aged 12). Also, Patient S spoke of dysphoria but there was no record of any exploration as to what 'dysphoria' meant to Patient S personally, references to 'painful thoughts and feelings' about her assigned gender but no exploration as to how these exhibited themselves or how they impacted on Patient S's wellbeing and functioning, no history of contact with CAMHS was recorded and Patient S's mental health was not explored in any detail.

574. The Tribunal considered it striking that there was reference in the report to the fact that Patient S was on the autistic spectrum ('ASD'), this had previously been referenced in the patient questionnaire, but had not been apparently explored with Patient S any further. In particular, Patient S described to Ms Colette a sense of 'feeling weird' and a 'lack of belonging' and yet there was no explanation or reflection upon the relative impacts of ASD versus the gender diversity as part of the overall assessment of Patient S's psychological presentation. In this regard, it was also noteworthy that the report indicated that Ms Avril Colette had previously been unaware of Patient S's ASD, and from which the Tribunal inferred, she could not have read the completed patient questionnaire prior to her consultation.

575. Accordingly, the Tribunal found paragraph 64ci4 of the Allegation proved.

#### Paragraphs 64cii and iii of the Allegation

64. Between February 2017 and November 2018, you failed to provide good clinical care to Patient S in that you:

c. relied upon an inadequate mental health assessment in that you:

ii. did not liaise with Patient S's mental health workers;  
**Found proved**

- iii. did not engage with Patient S's mental health workers when they actively sought to communicate with you;

**Found proved**

576. In any circumstance where a patient was seeking to transition and who had a history of involvement with mental health services, it was important in the opinion of the experts for there to be some liaison with them prior to assessment, diagnosis or treatment. Indeed, the proforma questionnaire which Patient S was sent by GenderGP implicitly acknowledged this fact in that it asked:

*"Has there been involvement of other agencies (e.g. Social Services, CAMHS, Voluntary Sector, Support Groups and contact details for these)?"*

577. In this case Patient S, in answering this question, alerted GenderGP to her previous involvement with CAMHS. This appeared to have been in or around early February 2017. Indeed, in June 2017 she had given permission to CAMHS to share information with GenderGP.

578. The only communication received by CAMHS from GenderGP was a letter faxed by Dr Webberley on 18 August 2017. This was a letter enquiring as to whether CAMHS would enter into a 'shared care agreement', to assist in relation to arranging blood tests and prescriptions. It was Dr Tasker's evidence that she was confused by this fax as it seemed Dr Webberley thought she was the patient's GP rather than a treating psychiatrist. CAMHS did not enter into any 'shared care agreement' with Dr Webberley and/or GenderGP and, because Dr Tasker thought she had received the fax in error, she tried to call him more than once, but received no answer and was unable to speak to anyone at GenderGP. At no time during which Patient S was under the care of Dr Webberley, did Dr Webberley contact CAMHS or, it would appear from the medical record, ever attempt to contact them beyond the email sent on 18 August 2017.

579. Accordingly, the Tribunal found paragraphs 64cii and iii of the Allegation proved.

#### Paragraph 64civ of the Allegation

64. Between February 2017 and November 2018, you failed to provide good clinical care to Patient S in that you:

- c. relied upon an inadequate mental health assessment in that you:

- iv. did not ensure the assessment process was adapted to account for Patient S's needs; **Found proved**

580. CAMHS medical records in relation to Patient S documented a diagnosis of ASD and, as previously indicated, this had been flagged to GenderGP in Patient S's initial questionnaire. It appeared that this had not been read by Ms Colette at the time of her telephone consultation with Patient S. In these circumstances, it does

not appear that there were any adaptations made to the assessment process, in respect of Ms Colette's consultation or thereafter, to account for any of the patient's needs with regards to her ASD. Furthermore, as Dr Kierans noted, there were numerous occasions documented in GenderGP's patient records, where Patient S made reference to difficulties that could have been related to her ASD, references to Patient S saying:

*"I struggle with questions and expressing myself with words', 'the stress of talking to people can render me non-verbal, such as when visiting the doctors', and when asked further questions by email 'I am sorry but I cannot answer some of those questions as I don't really understand them"*

581. Dr Kierans opined that Patient S was a young person who required additional 'scaffolding' to consider their gender identity, all of the relevant factors and the treatment information that she was being provided with to make a decision – an opinion with which the Tribunal agreed.

582. Accordingly, the Tribunal found paragraph 64civ of the Allegation proved.

#### Paragraph 64d of the Allegation

64. Between February 2017 and November 2018, you failed to provide good clinical care to Patient S in that you:

- d. reached a diagnosis of gender dysphoria based upon findings resulting from your inadequate assessment as set out at paragraphs 64b – c above; **Found proved**

583. In the light of those matters found proved in relation to paragraphs 64b-c, the Tribunal concluded, as opined by both experts during their evidence, that the diagnosis of gender dysphoria had been based upon an inadequate assessment.

584. In particular, the Tribunal accepted the analysis of Dr Kierans that the assessment was:

*"...too brief, was not thorough, did not explore all the expected areas and most worryingly did not take into account Patient [S's] ASD and associated difficulties with communication. Patient [S's] mental health history was not explored despite awareness of her history of engagement with CAMHS. There was no attempt to gather information from other sources such as CAMHS and attempts by the CAMHS doctor to link with Dr Webberley were not followed up. This meant that Dr Webberley initiated treatment on the basis of an inadequate assessment."*

585. Accordingly, the Tribunal found paragraph 64d of the Allegation proved.

#### Paragraph 64ei of the Allegation

64. Between February 2017 and November 2018, you failed to provide good clinical care to Patient S in that you:

e. prescribed oestrogen and anti-androgens to Patient S without:

i. being able to ensure it was clinically indicated;  
**Found proved**

586. In the light of the Tribunal's findings in relation to the inadequacy of the assessment of Patient S as set out in relation to paragraphs 64b-c, the Tribunal concluded that Dr Webberley could not have established that the prescription of oestrogen and anti-androgens were clinically indicated. Indeed, the Tribunal accepted that Dr Webberley's assessment was manifestly inadequate, that there was significant uncertainty that the diagnosis of gender dysphoria was a secure one and, consequently, there was inadequate evidence available to confirm that the medication prescribed was clinically indicated. The Tribunal acknowledged that it could have been that a diagnosis of gender dysphoria and prescription of sex hormones was appropriate. However, the clinical evidence available to Dr Webberley at that time was inadequate. Furthermore, as the Tribunal has previously determined, a diagnosis of gender dysphoria does not mean that the prescription of cross sex hormones is the only appropriate treatment.

587. Accordingly, the Tribunal found paragraph 64ei of the Allegation proved.

Paragraphs 64eii1 and 2, iii and 64fi and ii of the Allegation

64. Between February 2017 and November 2018, you failed to provide good clinical care to Patient S in that you:

e. prescribed oestrogen and anti-androgens to Patient S without:

ii. adequately monitoring, throughout the course of treatment, Patient S's:

1. physical response to treatment;  
**Found proved**

2. psychosocial response to treatment;  
**Found proved**

iii. discussing alternative treatments with Patient S;  
**Found proved**

f. continued to prescribe oestrogen to Patient S despite evidence that:

i. the dose was excessive; **Found proved**

- ii. Patient S was starting to experience known risks;  
**Found proved**

588. There was some evidence of follow up care and monitoring comprising periodic emails sent to Patient S, for example *“how are things going for you”*, sent by members of the admin staff, or the carrying out of blood tests to monitor the effects of the cross-hormone therapy prescribed. In relation to the former, the communications were non-specific, and none were with Dr Webberley directly. As to the latter, despite the monitoring blood tests indicating oestrogen concentrations that would, in the opinion of Dr Quinton, be excessively high even for maintenance therapy (let alone the initial phase of inducing feminisation) Dr Webberley did not address this issue, rather he persisted with the same oestrogen dose.

589. Moreover, following the prescription of cross-sex hormones on 24 July 2017, Patient S started to report that her emotions were more intense, and she was crying more readily. The cross-sex hormone therapy that Patient S was receiving had the known risk of hormone induced psychological or behavioural changes related to mood, anxiety, self-confidence, social interactions and behaviour.

590. There was no response from Dr Webberley regarding Patient S’s reported psychological symptoms either to suggest further discussion, exploration or whether Patient S required additional emotional support. The treatment continued without any reviews of psychological wellbeing until 16 April 2018, when Patient S was asked for an email update by a member of the administrative staff.

591. Although Patient S expressed satisfaction with her hormone treatment at this time, and her increased confidence in talking to people, she also reported having recently been prescribed medication for anxiety. There was no attempt by Dr Webberley to gain further information regarding Patient S’s anxiety or explore how it may, or may not, relate to their gender distress and/or transition. It was not until July 2018, one year after commencing cross-sex hormone treatment, that Patient S was offered a review session.

592. Notably, Patient S in response to the offer of a review session, asked for it to be postponed. Ms Jayne Olden emailed Patient S stating that Dr Webberley had a ‘responsibility and duty of care’ (to review treatments) to Patient S. Nevertheless, Ms Olden ultimately agreed that Patient S could simply email her with a comparison on *“how starting hormones compared to before starting hormones”* so that she could update GenderGP’s records and then they would not need to speak again for six months. In the event, there was no direct review of Patient S with Dr Webberley or any member of the GenderGP ‘team’ in the 16 months that Patient S was under the care of Dr Webberley until care was taken over by an NHS GIC in December 2018.

593. Accordingly, the Tribunal found paragraphs 64eii1 and 2, iii and 64fi and ii of the Allegation proved.

#### Paragraph 64g of the Allegation

64. Between February 2017 and November 2018, you failed to provide good clinical care to Patient S in that you:

- g. did not directly notify Patient S's GP, Dr ML, regarding any treatment you prescribed to Patient S; **Found proved**

594. There was no evidence that Dr Webberley had sought, at any time, to directly notify Patient S's GP of the treatment he had prescribed. The evidence suggested that the only other medical professional with whom Dr Webberley corresponded was Dr Tasker at CAMHS, to whom he wrote on August 2017, in error, as if she were the GP and not a psychiatrist, enquiring about the possibility of shared care.

595. Accordingly, the Tribunal found paragraph 64g of the Allegation proved.

Paragraphs 64hi, ii and iii of the Allegation

64. Between February 2017 and November 2018, you failed to provide good clinical care to Patient S in that you:

- h. did not make any changes to your clinical management of Patient S when they:
  - i. failed to obtain blood results upon request; **Found proved**
  - ii. failed to check their blood pressure upon request; **Found proved**
  - iii. returned abnormal results in relation to paragraph 64h.i – ii; **Found not proved**

596. In relation to paragraphs 64hi and ii, the Tribunal accepted that the hormones/medication that Patient S was being prescribed required monitoring, in particular, the monitoring of blood pressure, blood hormone levels and liver function tests. Despite repeated requests made by GenderGP to Patient S, that she should arrange blood testing and blood pressure monitoring, she failed to do so on six occasions between 18 July 2018 and 25 November 2018. Nevertheless, Dr Webberley carried on prescribing without alteration or supervision of the treatment. In these circumstances, the Tribunal determined that, at the very least, Dr Webberley should have made changes to his clinical management of Patient S, he failed to do so.

597. The Tribunal agreed with Dr Quinton's assessment that the various emails sent to the patient from GenderGP gave the appearance of clinical follow up but this did not reflect the reality and nothing was done that was clinically meaningful in terms of review of treatment and/or follow up care.

598. Accordingly, the Tribunal found paragraphs 64hi and ii of the Allegation proved.

599. In relation to paragraph 64hiii, the Tribunal did not consider that this sub paragraph added anything to the allegation at 64h and, in any event, was meaningless in its reference to sub paragraphs 64hi and ii.

600. Accordingly, the Tribunal found paragraph 64hiii of the Allegation not proved.

#### Paragraphs 64i(i) and (ii) of the Allegation

64. Between February 2017 and November 2018, you failed to provide good clinical care to Patient S in that you:

i. did not seek to conduct any follow up consultation between Patient S and:

i. yourself; **Found proved**

ii. an appropriately qualified person; **Found not proved**

601. The Tribunal accepted that it necessarily followed from its findings at paragraphs 64e, f and h that Dr Webberley should have sought to arrange a follow up consultation with Patient S – he did not. Accordingly, the Tribunal found paragraph 64i(i) of the Allegation proved.

602. In relation to paragraph 64i(ii) - as the Tribunal noted in relation to its finding in respect of paragraph 64c, there was an attempt to arrange a consultation between Ms Jayne Olden and Patient S for a review in July 2018. The Tribunal had no evidence as to Ms Olden's formal qualifications. Accordingly, the Tribunal could not conclude that she was not an appropriately qualified person.

603. Accordingly, the Tribunal found paragraph 64i(ii) of the Allegation not proved.

#### Paragraph 64ji of the Allegation

64. Between February 2017 and November 2018, you failed to provide good clinical care to Patient S in that you:

j. did not adequately communicate with Patient S in that you:

i. did not contact Patient S with adequate frequency throughout their period of treatment;  
**Found proved**

ii. inappropriately delegated communications to:

1. administrative staff; **Found proved**

2. counsellors; **Found proved**

- iii. failed to adapt communications appropriately to take into account the fact that Patient S is on the autistic spectrum; **Found proved**

604. The Tribunal, having considered the allegations at ji-iii carefully, were unable to identify any aspect which added to, and were not subsumed within, the allegations that the Tribunal had already considered and found proved in relation to paragraphs 64a-64i. Therefore, the Tribunal found paragraph 64j proved.

605. Accordingly, the Tribunal found paragraphs 64jii1 and 2 of the Allegation proved.

Paragraphs 64ki, ii and iii of the Allegation

64. Between February 2017 and November 2018, you failed to provide good clinical care to Patient S in that you:

- k. did not obtain informed consent in that you:
  - i. did not adequately assess Patient S's capacity to consent; **Found proved**
  - ii. failed to counter-sign the consent form; **Found not proved**
  - iii. commenced treatment without Patient S having signed the consent form. **Found not proved**

606. The allegation that Dr Webberley did not obtain informed consent was made in relation to a number of the transgender patients who feature in the Allegation. Accordingly, the Tribunal first considered the nature and extent of a medical practitioner's duty to obtain informed consent generally and, in particular, in the context of transgender medicine, including those cases in which the patient may be a child or adolescent.

607. A medical practitioner's obligation to obtain informed consent from their patient as a pre-requisite to commencing any form of elective treatment is at the heart of the medical practitioner's duty to their patient. Regardless of the nature of the elective treatment it should not be commenced unless, and until, the patient has provided consent that is informed.

608. The giving of informed consent involves the patient voluntarily agreeing to treatment in respect of which they have been given all the relevant information as to what the treatment entails, including the risks and benefits involved, what the reasonable alternative treatments are available and the risk and benefits to the patient in not receiving the treatment.

609. In order for a patient to give valid informed consent, they must have capacity to consent. This means that the patient must be able to understand the information that is being given to them and that they have the ability to use that information so as to make an informed decision.

610. The legal age of majority in England is 18 years. However, young people of 16/17 years old are presumed to have sufficient capacity to decide on and to consent to medical treatment in exactly the same way as adults i.e those over the age of 18 years. The wishes of a 16/17-year-old cannot be overruled by their parents, or others with parental responsibility over them, save in exceptional circumstances. Although generally, and specifically (as Dr Kierans opined), in transgender medicine, patients are encouraged to involve their parents/guardian in the consenting process, but the patient cannot be compelled to do so.

611. Children under the age of 16 years old do not have the capacity to consent to medical treatment unless they are ‘*Gillick competent*’ (*Gillick v West Norfolk and Wisbech Health Authority [1986] AC 112*).

612. A child will be Gillick competent if they have sufficient intelligence and understanding to fully appreciate the treatment proposed (including its risks and benefits) and the consequences of their refusal to accept that treatment.

613. In *Quincy Bell v The Tavistock and Portman NHS Foundation Trust & Others [2020] EWHC 3274 Admin*, the Divisional Court identified a number of principles relevant to the assessment of Gillick competence in relation to the receipt of transgender treatment by children:

*“- Firstly, the question as to whether a person under the age of 16 is Gillick competent to make the relevant decision will depend on the nature of the treatment proposed as well as that person’s individual characteristics. The assessment is necessarily an individual one. Where the decision is significant and life changing then there is a greater onus to ensure that the child understands and is able to weigh the information,*

...

*- Fourthly, however, that does not mean that every individual under 16 can achieve Gillick competence in relation to the treatment proposed. As we discuss below, where the consequences of the treatment are profound, the benefits unclear and the long-term consequences to a material degree unknown, it may be that Gillick competence cannot be achieved, however much information and supportive discussion is undertaken.*

*- Fifthly, in order to achieve Gillick competence it is important not to set the bar too high. It is not appropriate to equate the matters that a clinician needs to explain ... to the matters that a child needs to understand to achieve Gillick competence...*

*- Sixthly, we agree . . . , that in deciding what facts are salient and what level of understanding is sufficient, it is necessary to have regard to matters which are those which objectively ought to be given weight in the future although the child might be unconcerned about them now. On the facts of this case there are some obvious examples, including the impact on fertility and on future sexual functioning.”*

614. The case of *Quincy v Bell* was subject to an appeal to the Court of Appeal (*Quincy Bell v The Tavistock and Portman NHS Foundation Trust & Others [2021] EWCA Civ 1363*), in which the Lord Chief Justice, Lord Burnett of Maldon stated at paragraph 92:

*“We should not finish this judgment without recognising the difficulties and complexities associated with the question of whether children are competent to consent to the prescription of puberty blockers and cross-sex hormones. They raise all the deep issues identified in Gillick, and more. Clinicians will inevitably take great care before recommending treatment to a child and be astute to ensure that the consent obtained from both child and parents is properly informed by the advantages and disadvantages of the proposed course of treatment and in the light of evolving research and understanding of the implications and long-term consequences of such treatment. Great care is needed to ensure that the necessary consents are properly obtained. As Gillick itself made clear, clinicians will be alive to the possibility of regulatory or civil action where, in individual cases, the issue can be tested.”*

615. Having had regard to the principles referred to above and the case of *Re W (a Minor) (Medical Treatment: Court’s Jurisdiction) [1993] Fam. 64*, the Tribunal considered that the importance of the medical practitioner considering all the patient’s characteristics and circumstances cannot be understated when assessing whether a child, who is considering consent to puberty blocker treatment, is Gillick competent. The assessment cannot be limited to a consideration of the child’s age, maturity and apparent intelligence and understanding, but, in particular, it should include consideration of the child’s psychological presentation at the time that consent is obtained, and which may be relevant to, and impact upon, the patient’s ability to make an informed choice. If a patient is presenting with psychological symptoms, for example profound distress, anxiety or suicidal ideation, whether as a consequence of gender dysphoria or otherwise, the medical practitioner should have regard to this fact as part of the process of establishing Gillick competence.

616. In relation to the assessment of capacity of children and young people in practice, the Tribunal was assisted by the expert evidence of Dr Kierans whose evidence the Tribunal accepted in this regard.

617. Dr Kierans underlined the fact that:

*“In order to be determined to have capacity, the young person must demonstrate sufficient understanding of what the hormone blocker / cross-sex hormone will do, how it works, any side-effects, possible other impacts on emotional, cognitive and sexual development, and impacts over a*

*longer timeframe - as well as appreciating the possibility of as yet unknown impacts. In particular, the young person must demonstrate their consideration of the potential impact of the proposed treatment on genetic fertility and have had the opportunity to explore fertility preservation, with different pathways towards fertility discussed. The young person must comprehend that there is limited scientific evidence for the long-term benefits versus the potential harms of the intervention. They must also be aware that we as professionals have no way of being certain that they will continue to identify as transgender in the future, and recognise that some young people do have diverse outcomes, and come to regret treatment decisions, even those carefully and thoughtfully made."*

Dr Kierans highlighted that there is no standardised measure for assessment of capacity as the process is necessarily highly individualised.

618. Dr Kierans was at pains to emphasise that the assessment of capacity and the obtaining of informed consent should not be regarded as a single event but rather a process which takes place over time. She gave the example, that it was not unusual for young people who were very focused on endocrine intervention initially saying fertility was not important to them, but then after further conversations, changed their mind and decide to pursue fertility preservation.

619. With regard to the assessment of capacity and this being a process, Dr Kierans also explained that it was necessary to establish not only that the child, or young person, understands the information that they are being given but that they are also able to retain that information.

620. Finally, the Tribunal considered that it is not possible to be prescriptive as to the manner in which capacity is assessed in a child. However, the Tribunal noted the evidence of Dr Kierans that at her GIC, before a child/young person is prescribed puberty blockers/cross-sex hormones, the prescriber will have a comprehensive diagnostic report which includes consideration and conclusions regarding capacity. What the prescriber would do having received the report is revisit all the information with the patient again in a face-to-face appointment and ask the child questions to assess their level of comprehension and understanding. Following this discussion, there would then be an 'official' consent form and taking the child/young person through the form and getting them to document their understanding of the process.

621. Notwithstanding the fact that the Tribunal considered that it is not possible to be prescriptive as to the manner in which the capacity of a child is assessed, given that it is necessarily a very individualised process, the Tribunal was unable to envisage circumstances where a medical practitioner could properly assess a child's/young person's capacity to consent without having spoken with them face-to-face, be it in person or remotely, and more than a single brief discussion.

622. In respect of the issue as to whether a medical practitioner prescribing puberty blockers/cross-sex hormones is under a duty to obtain a consent form signed by the patient, the Tribunal determined that this would always be best

practise. However, the Tribunal considered that if the patient had, in fact, given informed consent, the failure by a doctor to obtain their patient's signature on a consent form would not vitiate that consent. It followed that it is not a pre-requisite to the obtaining of informed consent that the medical practitioner must counter-sign any consent form that may have been used.

623. The Tribunal, having concluded that the absence of a signed consent form did not vitiate informed consent that had been given, considered that the converse was also true. That is to say, the fact that a consent form may have been signed by the patient does not necessarily prove that the patient had capacity or that their consent was, in fact, informed.

624. The Tribunal was of the further view that, whether or not a consent form is signed by a patient, the medical practitioner would nevertheless be under a duty to maintain an adequate record of the consent process and the fact that informed consent had been given.

625. With regard to the specific allegation in relation to Patient S at paragraph 64ki, the Tribunal noted that at the relevant time she was 17 years old and of an age when capacity would ordinarily be presumed. However, as the Tribunal had previously observed, at the time Patient S first contacted GenderGP she had a diagnosis of an ASD and was under the care of CAMHS. GenderGP was aware of this fact and Dr Webberley should have been aware. Furthermore, the email correspondence as between Patient S, GenderGP and Dr Webberley, demonstrated that Patient S had difficulties in comprehension and understanding.

626. The Tribunal considered that email correspondence between Dr Webberley and Patient S in July 2017, shortly before he prescribed cross-sex hormones to Patient S, provided a striking example of Patient S's apparent deficits in comprehension and Dr Webberley's failure to have regard to them.

627. On 12 July 2017, Dr Webberley emailed Patient S:

*"Hi, do you have any questions or queries before we go ahead? Will your GP help with prescriptions at all? Do you need any help with ongoing counselling?"*

*I would be grateful if you could give me a detailed summary here of your thoughts and feelings and wishes. Your understanding of hormone treatment and the effects that will happen. The impact this will have on those around you and the impact it will have on you, including thoughts on your fertility.*

*Please give me as much information as you can in one big summary. Please also ask any questions you may have...."*

628. On 23 July 2017 Patient S replied:

*"Hello.*

*I am sorry but I cannot answer some of those questions as I don't really understand them.*

*I will answer what I can here:*

*We have not yet spoken to the gp regarding prescriptions.*

... [Patient S detailed some of the effects that hormone treatment can have, which appeared to have been obtained from information leaflets previously sent to Patient S by GenderGP]

*In theory hormone treatment will greatly help alleviate my gender dysphoria and thus improve my mood, it will hopefully help me pass better in public. In the past few months my dysphoria has gotten worse due to things that hormone therapy would help greatly, this worsening severely affected my ability to function in college for example, so getting hrt asap is quite important to me. I have thought about fertility but quickly came to the conclusion that having biological children is not right for me for reasons that will not change.*

*I would appreciate it if we could go ahead."*

629. Dr Webberley replied the next day, 24 July 2017:

*"Many thanks, I shall get your prescription ready and the admin team will be in touch with instructions."*

630. The Tribunal determined that in the light of Patient S's diagnosed ASD, her limitations in comprehension and understanding as illustrated by the above emails, and earlier emails, Dr Webberley did not adequately assess Patient S's capacity to consent in circumstances where he plainly should have done so.

631. Furthermore, the Tribunal considered that in the circumstances of this case it would have been impossible for Dr Webberley to adequately assess her capacity without speaking with her face-to-face – he did not even speak to her on any occasion.

632. In reviewing the evidence in relation to this allegation the Tribunal noted (although it was not necessary for the purposes of determining this specific allegation) that the reference in Patient S's email of 23 July 2017 to her having thought about fertility but quickly came to the conclusion that having biological children was not right for her, was the only reference to Patient S's views on fertility. Prior to this there had been no discussion with Patient S, a 17-year-old transitioning from male to female.

633. Given that the process of obtaining informed consent necessarily requires the capacity of the patient to have been established the Tribunal, accordingly, found paragraph 64ki of the Allegation proved.

634. The Tribunal found paragraphs 64kii and iii of the Allegation not proved for the reasons set out above in relation to the Tribunal's consideration of the duties of a medical practitioner with regard to the signing of consent forms.

Paragraph 65a, 65bi, 65bii, and 65c of the Allegation

65. You provided treatment to Patient S as outlined at paragraph 64 above:
- a. outside the limits of your expertise as a consultant gastroenterologist; **Found proved**
65. You provided treatment to Patient S as outlined at paragraph 64 above:
- b. without the necessary qualifications and training and experience in:
    - i. transgender medicine; **Found proved**
    - ii. assessing capacity and autonomy in an adolescent with mental health issues; **Found proved**
65. You provided treatment to Patient S as outlined at paragraph 64 above:
- c. whilst failing to adhere to a recognised training pathway in transgender medicine. **Found proved**

635. As to paragraph 65, the Tribunal first considered what would be the minimum qualification, training and/or experience required for the provision of care to transgender patients generally and specifically in relation to Patient S.

636. GMP provides that with regard to knowledge, skills and performance, doctors must:

- *“Provide a good standard of practice and care.*
  - o *Keep [their] professional knowledge and skills up to date.*
  - o *Recognise and work within the limits of [their] competence”*

637. The expert evidence the Tribunal heard was that, in most areas of medicine, a UK specialist can be readily defined as such by their entry in the GMC Specialist Register, and that doctors on the General Practitioners Register can also declare a special interest, or extended role. However, in respect of transgender medicine the only UK specialties in which some knowledge in the field is acquired in training are psychiatry, diabetes and endocrinology, and sexual and reproductive health, but in none of these is it a primary core competency. Therefore, the practise of transgender medicine is fundamentally experiential, being based upon the

accumulation of relevant clinical experience appropriately supervised and reflected upon.

638. Training in transgender medicine therefore currently lacks any formal entry or exit points, or a structured curriculum, although Dr Quinton opined:

*“(British Association of Gender Identity Specialists), or possibly WPATH (World Professional Association for Transgender Health) might provide supportive evidence. Practitioners are typically listed on the GMC Register as Psychiatrists, or less commonly, Endocrinologists, GPs, or Reproductive Health specialists.*

*Whatever their background, a specialist in adult (trans)Gender medicine should have fulfilled certain basic requirements to a standard consistent with GMC Good Medical Practice*

- *They should be clinically competent in undertaking a comprehensive MSE [Mental State Examination] and in making a diagnosis of gender incongruence.*
- *They should have undertaken adequate (in respect both of length-of-time and quality) clinical training under the supervision of a reputable Specialist/Consultant with nationally-recognised expertise in the area of (trans)Gender medicine.*
- *They should show evidence of ongoing professional capacity to undertake the role of Gender specialist, through a combination of CPD activity, appraisal portfolio and regular peer-to-peer interactions with colleagues, preferably as part of a multidisciplinary team.*
- *To inform lifelong learning and maintenance of clinical standards, patient records should be robust enough to allow audit of client outcomes, and for adverse events to be documented transparently. In particular, data on rates of reversion to birth gender among current and former clients should be actively sought and regularly reviewed as far as possible.”*

639. The Tribunal accepted the evidence of Dr Quinton in this regard.

640. The Tribunal also had regard to the evidence of Dr Kierans and the provisions of the WPATH (2012) guidelines that state that mental health professionals are best prepared to conduct assessments of gender dysphoria. However, it is also recognised that other health professionals with appropriate training may conduct these assessments, particularly as *part of an MDT* [Tribunal’s emphasis].

641. The Tribunal further noted that GMC guidance in respect of ‘bridging prescriptions’ referred to above, and which emanates from ‘*Good Practice Guidelines For The Assessment and Treatment of Adults With Gender Dysphoria*’ issued by the Royal College of Psychiatrists, defines an ‘*experienced gender*

*specialist*' as someone who has evidence of relevant training and at least two years' experience working in a specialised gender dysphoria practice such as an NHS GIC.

642. The Tribunal having considered what the minimum requirements in terms of qualifications, training and experience for a medical practitioner in providing care to transgender patients generally and specifically in relation to Patient S, and other patients, went on to consider the extent of Dr Webberley's qualification, training and experience at the relevant time.

643. The Tribunal considered that, had Dr Webberley been working within a fully functioning MDT, he would not necessarily have been required to possess the qualifications, training and experience in all aspects of transgender medicine and in the assessment of capacity in an adolescent with mental health issues. However, as the Tribunal had already found, Dr Webberley was not operating as part of a functioning MDT, rather he was essentially acting autonomously and was the sole decision maker, although the Tribunal acknowledged he drew upon the opinion of other professionals from time to time. The Tribunal determined that Dr Webberley had for all intents and purposes taken on the role of the MDT upon himself.

644. In these circumstances the Tribunal determined that Dr Webberley needed the qualifications, training and experience in all aspects of transgender care as set out above.

645. Dr Webberley retired from the NHS in 2016. At this time, he was a consultant physician specialising in gastroenterology and he had been practising in the sphere of delivering Acute Medicine Care and in an NHS management role. This appeared to have been approximately a year before he took on the active clinical management of GenderGP in May 2017. GenderGP documentation described Dr Webberley as being the *"clinical manager on behalf of Dr Webberley services MyWebDoctor and GenderGP"*.

646. The Tribunal accepted, as had been acknowledged by the GMC that:

*"in fulfilling his duties as a consultant physician in the NHS setting... [and] that as a consultant physician he would be very experienced in:*

- a. Assessing patients*
- b. Examining patients*
- c. Arranging for patients to be assessed by other specialties*
- d. Liaising with colleagues and/or others also involved in the patient's care*
- e. Diagnosing patients*
- f. Dealing with Consent and Capacity in adult patients*
- g. Treating patients, including prescribing for them*
- h. Formulating a Treatment Plan*
- i. Reviewing the patient to see how treatment has progressed."*

647. With regard to Dr Webberley's qualifications, training and/or experience obtained subsequent to his retirement, and before he provided treatment to

Patients S - Y, there was no evidence in his CV that Dr Webberley had obtained any further relevant formal qualifications or training following his retirement.

648. With regard to the qualifications required for the prescription of hormones to minors with gender dysphoria, it was Dr Quinton's evidence that:

*"Physicians with background in General (Internal) Medicine (GIM) and its associated subspecialties, including Gastroenterology, are neither trained, nor indemnified to deliver safe, effective and evidence-based medical care – including drug prescriptions – to minors as per GMC standards, except in the context of a specialist multidisciplinary team (MDT) with senior Paediatric support, or conceivably in a medical emergency.*

*The prescription of GnRHa drugs to cis-gendered minors in order to arrest puberty is a highly specialist area of practice where the evidence basis for clinical practice is not overwhelming and a general Paediatrician, without experience or training in Paediatric Endocrinology, would be operating outside their expected level of competency were they to be prescribing autonomously.*

*Moreover, their prescription to minors who have initiated normal puberty in their birth gender – specifically for the purpose of arresting puberty in the context of adolescent gender dysphoria – is a particular area of hyper-specialist medical practice in the UK and elsewhere.*

*Non randomised controlled studies of GnRHa use for adolescent sexual dysphoria and long-term observational safety data are still accumulating in specialist centres across the world (the Tavistock in the UK). Therefore, all but the most experienced tertiary Paediatric Endocrinologists would be operating outside their expected level of competence were they to be autonomously prescribing, let alone requesting the initiation of such scripts in primary care.*

*It is commonly assumed that the purpose of GnRHa treatment in gender dysphoric minors is to prevent puberty from initiating. However, this is not the case. For a significant proportion of minors experiencing gender confusion in childhood, the physical and psychological changes of puberty act to reaffirm them in the gender identity of their birth. Therefore, a diagnosis of gender dysphoria cannot be reliably entertained until the minor has begun to experience the changes arising from early puberty; objectively finding these to be undesirable or distressing."*

649. In Dr Webberley's appraisal documents in respect of an appraisal that occurred on 12 November 2017, after he had started treating transgender patients at GenderGP and in particular Patient S, it was stated:

*"Dr Webberley retired from NHS work in June 2016 where he was working as a Consultant Gastroenterology. He now works as a Locum Physician in a Transgender Medical Clinic and also a prescriber for and on line pharmacy.*

*Dr Webberley is a very accomplished clinician and medical manager and has contributed extraordinarily to the wider cause of NHS in Wales. I am pleased to know that he has made an uneventful recovery from his recent knee surgery. It was impressive to hear and feel Dr Webberley's enthusiasm towards less developed area of medicine where the transgender population is not served well..."*

650. The evidence demonstrated that it was in or around May 2017, following Dr HW's practise being restricted, that Dr Webberley took on responsibility for transgender patients at GenderGP.

651. The Tribunal considered it of note that on 21 June 2017 Dr Webberley emailed the mother of another transgender patient at GenderGP (Patient T) stating:

*"Hi K, many thanks for your message. I am looking after Dr (HW's) patients while she is unable to. I am able to prescribe in cases of emergency and to save young patients from distress or risk if they were to have their treatment withdrawn."*

652. The Tribunal considered this statement to be significant to the extent that, firstly, it did not make any reference to Dr Webberley's specialism or expertise in transgender medicine and secondly, it demonstrated that Dr Webberley considered there were limitations on his ability to prescribe to transgender patients, in this instance, puberty blockers. The Tribunal inferred that Dr Webberley's email was alluding to the GMC 'Bridging Guidance' contained in the GMC's 'Treatment pathways: referral to a gender identity clinic' ('GIC') that states:

*"...the GP or other medical practitioner involved in the patient's care may prescribe 'bridging' endocrine treatments as part of a holding and harm reduction strategy while the patient awaits specialised endocrinology or other gender identity treatment and/or confirmation of hormone prescription elsewhere or from patient records"*

653. In considering the issue of the extent of Dr Webberley's experience in transgender medicine at the time that he was responsible for the treatment of Patients S-Y, the Tribunal was mindful of the fact that up until May 2017, Dr HW was a GP practising at GenderGP. The Tribunal did not have any evidence with regard to Dr HW's qualifications, training and/or experience in the field of transgender medicine. However, the Tribunal considered that even if Dr HW was a GP with a special interest in transgender medicine, the evidence did not support a conclusion that Dr Webberley, whether by being supervised or working in conjunction with Dr HW, had gained sufficient experience to demonstrate competence in the provision of treatment to his transgender patients.

654. Firstly, if such supervision/co-working had occurred, it would have been limited to the period between Dr Webberley's retirement in 2016 and restrictions being placed on Dr HW's practise in May 2017. Furthermore, Dr Webberley himself did not suggest in any of the communications he sent to the GMC during the course of their investigations in 2018 and thereafter, that his experience or competence in

transgender medicine had been gained through working in conjunction with, or under the supervision of, Dr HW (although the Tribunal noted that there was reference in Dr Webberley's CV to the joint publication with Dr HW of several articles in the field of transgender medicine).

655. In reaching this conclusion, the Tribunal had regard to the assertion made in a document provided by Dr Webberley to the GMC in 2018 regarding the care that had been provided to Patient V stating:

*“Dr Webberley is now one of the leading gender specialists in the UK, treating transgender patients of all ages. He has the largest caseload of any doctor and currently has 1500 transgender patients under treatment and active follow up, including 250 young people.”*

656. This assertion was similar to that which had been stated in a letter to Patient V's GP in July 2018 when introducing himself:

*“My name is Dr Mike Webberley and I am a consultant physician specialising in transgender care. Our MDT has given advice to several thousand trans and nonbinary patients as well as initiating hormone therapy to nearly 1500 patients of all ages. Our service adheres to GMC guidelines on transgender care and remote care - and we care for patients via email, telephone, video-link and face-to-face as appropriate.”*

657. Notably, this letter did not refer to Dr Webberley as being the treating doctor for the many patients referred to, rather it referred to the 'MDT' as having given advice as well as initiating hormone therapy.

658. Furthermore, the Tribunal considered that these assertions in relation to Dr Webberley's experience in treating transgender patients, at the relevant time, were inconsistent with the terms of the email sent by Dr Webberley to Patient T's mother on 27 June 2017, as referred to above, and which indicated that Dr Webberley's ability to prescribe puberty blockers was limited to prescribing in cases of emergency.

659. The Tribunal concluded that in relation to Patient S, who became Dr Webberley's patient at GenderGP in or around May 2017, he was providing treatment outside the limits of his, undoubted, expertise as a gastroenterologist. He did not have the necessary qualifications, training and experience in transgender medicine, or in the assessment of capacity and autonomy in an adolescent with mental health issues. In the latter regard, this was by reason of the fact that Dr Webberley lacked relevant training, qualification, or experience as a mental health professional. Finally, there was no evidence to support the conclusion that Dr Webberley was adhering to any recognised training pathway in transgender medicine.

660. Accordingly, the Tribunal found paragraph 65a, 65bi and ii, and 65c of the Allegation proved.

## Patient T

661. In June 2016, Patient T, then aged 10 years old, contacted their GP, Dr Dhrushil Patel, with their mother asking for help around gender dysphoria issues. A referral to the Tavistock Clinic was made in July 2016.

662. In October 2016, Patient T's mother first contacted GenderGP and informed them that Patient T had been put on a 10-month waiting list before they could be seen at the Tavistock Clinic. It appeared that shortly thereafter Patient T became a patient of Dr HW.

### Paragraph 66a of the Allegation

66. Between May 2017 and January 2018, you failed to provide good clinical care in that you:

a. did not establish an adequate MDT; **Found proved**

663. In December 2016 and January 2017, Patient T was assessed by Dr Vickie Pasterski, Clinical Psychologist, who subsequently reported to Dr HW at GenderGP.

664. In March 2017, Dr HW wrote to Dr Patel explaining that Patient T had been seeing her and a psychologist, to discuss their gender identity. Dr HW advised that she had discussed hormone blockers with Patient T and their family and the implications this could have on fertility. Dr HW asked the Practice to prescribe and administer GnRH agonists (puberty blockers) and arrange blood tests under her supervision and a 'Shared Care Agreement'.

665. On 20 June 2017, Dr Webberley emailed Patient T's mother to inform her that he was looking after Dr HW's patients whilst she was unable to do so. He stated:

*"I am able to prescribe in cases of emergency and to save young patients from distress or risk if they were to have their treatment withdrawn..."*

666. From Dr Patel's perspective, Dr Webberley's first involvement in relation to the care of Patient T was at the end of June 2017, when he requested the GP Practice to arrange blood tests to monitor the effectiveness of the puberty blockers being prescribed to Patient T.

667. Dr Patel had further correspondence with Dr Webberley in the subsequent months, during which time he became concerned in relation to the treatment that Patient T was receiving, and Dr Webberley's involvement in that treatment.

668. On 10 November 2017, Dr Patel spoke to Dr Webberley on the phone. His evidence was that he had been told by Dr Webberley that Dr HW was no longer involved in Patient T's care, nor was he her supervisor. He explained his training and background qualifications which he said he felt gave him the credentials to deal with Patient T's care. He also explained that he was *"no longer initiating treatment on*

*new patients” and just continuing bridging until taken over by the Tavistock Clinic as he explained “suddenly stopping [puberty blockers] can have a negative impact”.*

669. This telephone conversation was followed by a letter from Dr Webberley to Dr Patel, dated 21 November 2017, in which Dr Webberley stated that he had assumed the clinical care for Patient T from the beginning of May 2017 as a result of Dr HW having had restrictions placed on her by the GMC. He stated he had continued the care of Patient T in terms of repeat prescriptions for puberty blockers (put in place) after a *‘lengthy and complete assessment process by trained psychologists and Dr HW during ‘our’ MDT process’*. Dr Webberley explained that:

*“on the balance of risk [he] felt it was much safer for Patient T to continue with puberty blockers rather than have them withdrawn abruptly”.*

670. Dr Webberley further referenced the GMC guidance relating to bridging prescriptions for patients with gender dysphoria.

671. The Tribunal determined that Dr Webberley had not been involved in, nor had responsibility for, the care of Patient T prior to May 2017. Further, by this time, Patient T had already been assessed and puberty blockers prescribed. Accordingly, the Tribunal did not consider that it was necessary to determine whether there had been an adequate MDT in relation to the initial assessment and decision to prescribe puberty blockers to Patient T because this pre-dated Dr Webberley’s involvement.

672. Therefore, the Tribunal was required to consider whether, at the time Dr Webberley took over the care of Patient T, it was nevertheless necessary for there to be an MDT in place.

673. In this regard the Tribunal heard evidence from Dr Kierans who opined as to the responsibilities of a doctor who takes over the care of a patient in this context, namely, a child who has been diagnosed with gender dysphoria and is receiving ongoing puberty blocker medication. It was Dr Kierans’ opinion, which the Tribunal accepted, that any doctor in these circumstances has a responsibility to evaluate the prior assessment and diagnostic process to ensure that continuing treatment was appropriate or, as she stated in oral evidence, to review the diagnosis and treatment with ‘fresh eyes’. Furthermore, in the context of pre-pubertal children receiving treatment for gender dysphoria continuing review is especially necessary.

674. For the reasons previously stated, Dr Webberley did not have the necessary qualification, training or experience to review the treatment of a child diagnosed with gender dysphoria and who was receiving ongoing puberty blocker medication. The Tribunal considered therefore that this could only have been achieved with a functioning MDT and which, in the case of Patient T, would have needed the input of a paediatric mental health professional or paediatric endocrinologist (or gender specialist). The Tribunal concluded that there was no evidence of there being an adequate MDT in existence. There was no paediatric mental health professional or paediatric endocrinologist/gender specialist involved whilst Dr Webberley had responsibility for the care of Patient T.

675. Further, the Tribunal noted that during this period (July 2017), there were concerns regarding Patient T's mental health in that Patient T's family had raised the possibility of foetal alcohol spectrum disorder and there had been no referral to CAMHS. The Tribunal considered that this was an illustration of the need for there to be ongoing review of a patient even after diagnosis and prescription.

676. The Tribunal had regard to the email from Dr Webberley to Patient T's mother, on 21 June 2017, and the suggestion, implicit in Dr Webberley's conversation with Dr Patel and his letter of 27 November 2017, that his role in providing care was limited to providing bridging prescriptions until such time as the care of Patient T was taken over by the Tavistock Clinic. The Tribunal accepted that, if this was the only role Dr Webberley was fulfilling, then it may not have been necessary to have an established MDT. However, the Tribunal, having considered the GMC's criteria in relation to bridging prescriptions for the treatment of patients with gender dysphoria, which had been derived from guidelines issued by the Royal College of Psychiatrists, concluded that Dr Webberley's ongoing prescribing to Patient T could not be described as 'bridging'. Patient T had not previously been self-prescribing from an unregulated source, and although Dr Webberley had purported to be mitigating a risk self-harm, he had not sought the advice of an experienced gender specialist in reaching this conclusion.

677. The Tribunal determined that, absent a proper basis to provide a bridging prescription, and given that he was providing prescriptions on a repeat basis, he was acting autonomously in the role of Patient T's treating clinician without an MDT in place. Furthermore, if in reality Dr Webberley was simply providing bridging for a former patient of Dr HW and GenderGP pending Patient T being assessed or being provided treatment from an alternative specialist, in the Tribunal's judgement, Dr Webberley should have facilitated the transfer of Patient T's care to a suitable gender specialist. At the relevant time Patient T had been referred to the Tavistock Clinic and had been seen by them as early as May 2017. The Tribunal could see no reason why Dr Webberley would not have liaised with the Tavistock Clinic if his role was simply a bridging one. The fact that he did not, was in the Tribunal's view, indicative of the fact that he was not in reality simply providing 'bridging' treatment.

678. Accordingly, the Tribunal found paragraph 66a of the Allegation proved.

#### Paragraph 66b of the Allegation

66. Between May 2017 and January 2018, you failed to provide good clinical care in that you:

- b. did not advise Patient T's GP ('Dr DP') that you had taken over the care of Patient T from Dr HW; **Found not proved**

679. The Tribunal determined that Dr Webberley took over the care of Patient T, in or around May 2017, and that it was the evidence of Patient T's GP, Dr Patel, that his Practice was unaware of Dr Webberley's involvement in Patient T's care until November 2017 and Dr Patel had assumed that it was Dr HW who had the care up

until this time. The Tribunal considered that Dr Webberley should have informed Patient T's GP that he had formally taken over Patient T's care earlier than he did. However, having regard to the stem of paragraph 66 which alleges a time period between May 2017 and January 2018, the Tribunal found this allegation not proved because Dr Webberley did advise Patient T's GP that he had taken over care from Dr HW in November 2017. The Tribunal did not consider it appropriate, given the absence of Dr Webberley or him being represented, to amend the allegation at this late stage.

680. Accordingly, the Tribunal found paragraph 66b of the Allegation not proved.

#### Paragraphs 66ci and ii of the Allegation

66. Between May 2017 and January 2018, you failed to provide good clinical care in that you:

- c. sought a shared-care agreement with Dr DP which was inappropriate in that you were unqualified to:
  - i. autonomously prescribe to minors; **Found proved**
  - ii. sign-off on shared-care agreement involving minors; **Found proved**

681. Patient T's medical records and the evidence of Dr Patel established that Dr HW had sought a shared care agreement with Dr Patel's Practice, and which would have involved the Practice both prescribing and performing blood tests for Patient T. The Practice, in the event, did not enter into a shared care agreement although it appeared they subsequently carried out some blood tests, but they did not prescribe to Patient T.

682. In October 2017 Dr Webberley, having taken over the care of Patient T wrote to the GP Practice enclosing a prescription he had issued for Patient T. Within the letter he invited the Practice to consider prescribing to Patient T themselves through a shared-care agreement with Dr Webberley providing ongoing support with dosages and monitoring.

683. The Tribunal received expert opinion evidence from Dr Quinton as to Dr Webberley's qualification to autonomously prescribe to minors and sign off on shared care agreements involving minors and the Tribunal had regard to the findings it had made in relation to Dr Webberley's qualification, training and experience with regard to transgender medicine.

684. The Tribunal concluded that, as a Consultant Physician specialising in adult gastroenterology, Dr Webberley was not qualified to autonomously prescribe puberty blockers/cross-sex hormones to any transgender patients, much less, was he qualified to prescribe any medication to a child (other than in an emergency). It therefore followed that Dr Webberley was not qualified to enter into, or 'sign off on', a shared care agreement, whereby puberty blockers would be prescribed to a child

by another doctor on his advice as part of a shared care agreement. Although this was not the subject of the allegation, the Tribunal noted that Dr Webberley had himself been prescribing puberty blockers to Patient T, a minor, since taking over care from Dr HW.

685. Accordingly, the Tribunal found paragraphs 66ci and ii of the Allegation proved.

Paragraphs 66di and ii of the Allegation

66. Between May 2017 and January 2018, you failed to provide good clinical care in that you:
- d. continued to prescribe injections of gonadotrophin releasing-hormone ('GnRH') off-licence to Patient T without:
    - i. up to date blood tests; **Found proved**
    - ii. any periodic appraisals of Patient T's condition through face-to-face or video consultations; **Found proved**

686. The Tribunal accepted the evidence of Dr Quinton in relation to the need to obtain blood tests for the purpose of monitoring the patient's response to puberty blocker treatment on an ongoing basis. Indeed, Patient T's GenderGP medical records demonstrated that Dr Webberley recognised this need himself and a number of blood tests were performed whilst Patient T was under his care.

687. On 17 October 2017, Dr Webberley wrote to Patient T's GP advising that the next blood tests were due around 31 October 2017. It was Dr Patel's evidence that he had become aware that these blood tests had not been performed and that nevertheless, Dr Webberley had continued to prescribe puberty blockers, in particular, on 10 November 2017. As a result of this realisation Dr Patel, in due course, contacted Patient T's mother to raise concerns as to Patient T's care. Given that the last recorded blood test, prior to 10 November 2017, was August 2017, and that the blood test requested by Dr Webberley in October 2017 had not been obtained, the Tribunal found paragraph 66di proved.

688. As to paragraph 66dii, the Tribunal having considered GenderGP's patient record concluded that there had not been any appraisals of Patient T's condition following Dr Webberley's taking over care in May 2017 beyond occasional email correspondence with Patient T's mother. At no stage did Dr Webberley speak to Patient T directly, whether in person or by video or other means. In the light of Dr Kierans' evidence relating to a doctor's responsibilities to reassess and review when taking over the care of a patient from another doctor and the need to review a child receiving puberty blocker treatment generally, the Tribunal concluded that he should have seen Patient T in person, or at the very least, by video consultation.

689. Accordingly, the Tribunal found paragraphs 66dii of the Allegation proved.

#### Paragraph 66e of the Allegation

66. Between May 2017 and January 2018, you failed to provide good clinical care in that you:
- e. did not arrange an assessment of Patient T by an appropriately qualified expert in transgender minors; **Found proved**

690. The Tribunal have already found that Dr Webberley did not have the qualification, training or experience to assess a transgender patient, be they an adult or a minor. Further, the Tribunal have found that Dr Webberley should have re-evaluated and kept under review Patient T's diagnosis and treatment. This would necessarily have required the involvement of a qualified expert in the treatment of transgender minors. This was not arranged by Dr Webberley, therefore the Tribunal found paragraph 66e of the Allegation proved.

#### Paragraph 66f of the Allegation

66. Between May 2017 and January 2018, you failed to provide good clinical care in that you:
- f. did not recognise that the initial psychological assessment was insufficiently detailed; **Found proved**

691. Prior to Dr Webberley taking over the care of Patient T, as the Tribunal has already noted, they had been assessed by Dr Pasterski who had seen Patient T on two occasions, the first in December 2016, the second in January 2017.

692. Dr Kierans gave evidence in relation to the psychological assessment that should be carried out before puberty blockers are prescribed. It was her experience from the GIC in which she worked that the assessment process would usually involve a minimum of 3-6 assessment sessions, although, in reality patients would often be seen on more occasions depending on the levels of the complexity of the case. The assessment process usually takes six months to a year, or longer as needed.

693. The Tribunal considered that whereas it is not possible to be prescriptive as to the number of sessions, or the period over which they should be performed, the reasons why the assessment process would require numerous sessions over a period of time were self-evident. Young patients, and children in particular, need careful psychological assessment before a diagnosis of gender dysphoria and a decision to prescribe puberty blockers. The Tribunal received evidence that it does not follow that a child diagnosed with gender dysphoria will or should necessarily be prescribed puberty blockers. This is because a child/young person's gender identity may be confused or obscured by other factors in their life such as family dynamics, autistic disorders, child abuse or emerging sexuality, therefore psychological assessment and exploration is necessary to establish a secure diagnosis and

determine appropriate treatment, if any. Furthermore, there will, as has previously been observed by the Tribunal, issues of capacity and consent that will need to be resolved over a period of time.

694. With regard to the psychological assessment initially carried out by Dr Pasterski, the Tribunal noted that not only was it limited to two sessions over a period of only six weeks, but also Dr Kierans was critical as to the detail contained within the assessments.

695. In Dr Kierans' opinion the assessments were insufficiently detailed in a number of respects and included, but were not limited to:

- Inadequate history of Patient T's disrupted attachments and developmental trauma;
- Limited exploration of body image;
- No discussion of developing sexual identity;
- No discussion relating to future fertility and potential impact thereon;
- Limited discussion relating to learning difficulties, attention difficulties and information processing difficulties.

696. Whilst acknowledging that there was sufficient evidence from both Patient T and their parents to demonstrate a persistent distress about assigned sex, Dr Kierans also noted that Patient T had reported to Dr Pasterski that they had not:

*“expressed 100% certainty in the role as male”.*

697. In Dr Kierans' opinion, this would not necessarily have precluded a diagnosis of gender dysphoria but the statement warranted further exploration prior to making such a diagnosis.

698. The Tribunal accepted Dr Kierans' evidence with regard to the detail of Dr Pasterski's assessment and, in the light of its conclusions with regard to the responsibilities of Dr Webberley upon taking Patient T as his patient, he should have recognised that Dr Pasterski's psychological assessment was insufficiently detailed.

699. Accordingly, the Tribunal found paragraph 66f of the Allegation proved.

#### Paragraphs 66gi, ii and iii of the Allegation

66. Between May 2017 and January 2018, you failed to provide good clinical care in that you:

g. review Patient T's consent to treatment when it was apparent that:

i. not all risks had been discussed with Patient T;

**Found not proved**

- ii. Patient T's capacity to consent had not been adequately considered; **Found not proved**
- iii. Patient T's consent form had been received remotely, not affording them the opportunity to ask questions; **Found not proved**

700. As to paragraph 66g, implicit within the allegation was the assertion that certain matters relating to the care previously provided by Dr HW (i.e i-iii) were apparent to Dr Webberley. In this regard, the Tribunal was mindful of the fact that there was no evidence of Dr Webberley having been involved in the care of Patient T prior to May 2017, and that Patient T's patient records demonstrate that Dr HW had communicated and consulted with both Patient T and their mother. Indeed, there is in the records copy emails in December 2016 and January 2017 in which Dr HW and Patient T's mother corresponded with regard to a "*recent meeting*" that had occurred at which it appeared Dr HW had met Patient T's mother as well as Patient T, and possibly Patient T's father. Subsequently, Patient T's mother indicated that they were going to "*think things over*" as they wanted to be certain that they were doing the right thing for the right reasons and that it involved such a "*very big decision*".

701. The Tribunal considered that in the light of this email communication and having considered Patient T's medical record for the period before Dr Webberley's involvement, the Tribunal was not satisfied, on the balance of probabilities that the matters alleged in paragraphs 66gi-iii would have been 'apparent' to Dr Webberley when he took over the care of Patient T even assuming that all risks had not been discussed, and capacity to consent had not been adequately considered with Dr HW.

702. Accordingly, the Tribunal found paragraphs 66gi, ii and iii of the Allegation not proved.

#### Paragraph 66h of the Allegation

66. Between May 2017 and January 2018, you failed to provide good clinical care in that you:

- h. inappropriately relied solely on Patient T's mother to provide updates relating to Patient T's condition. **Found proved**

703. As the Tribunal had previously found, Dr Webberley should have re-evaluated the diagnosis and care Patient T was receiving once Patient T became his patient and continued to review throughout. The Tribunal had also observed that on no occasion had Dr Webberley ever spoken to, much less met Patient T in person or remotely. The patient record indicates that Dr Webberley's only source of information as to his patients' condition, with the exception of occasional blood test results, was from Patient T's mother. The Tribunal considered this was wholly inappropriate as Dr Webberley should have been communicating directly with his patient.

704. Accordingly, the Tribunal found paragraph 66h of the Allegation proved.

Paragraph 67a of the Allegation

67. You provided treatment to Patient T as outlined at paragraph 66 above:
- a. on behalf of Dr HW whilst she was subject to an interim order of suspension; **Found not proved**

705. The GMC's case in relation to this allegation relied upon the evidence of Dr Patel who stated that in November 2017 he had spoken to Patient T's mother, and she had told him that Dr HW was responsible for the care of Patient T but Dr Webberley was the person responsible for writing the prescriptions. Patient T's mother had also given Dr Patel the impression that Dr HW was being supervised by Dr Webberley, although Dr Patel said he did not know whether Patient T's mother had been told this explicitly or whether it was something that she had assumed. However, the Tribunal considered GenderGP's medical record in respect of Patient T and could find no evidence that Dr HW had had any involvement with Patient T after Dr Webberley had taken over their care.

706. The Tribunal noted the letter sent to Dr Patel, dated 21 November 2017, when Dr Webberley reiterated that he had taken over responsibility of Dr HW's patient following the restriction on her practice. The Tribunal also noted that it had not been provided with any direct evidence by the GMC with respect to Dr HW's restrictions on her registration.

707. In these circumstances, the Tribunal was not satisfied that Dr Webberley's provision of treatment to Patient T was 'on behalf of Dr HW' rather, the Tribunal determined that he was acting as an autonomous practitioner within GenderGP.

708. Accordingly, the Tribunal found paragraph 67a of the Allegation not proved.

Paragraph 67b of the Allegation

67. You provided treatment to Patient T as outlined at paragraph 66 above:
- b. outside the limits of your expertise as a consultant gastroenterologist; **Found proved**

709. For the same reason as the Tribunal has set out in relation to Patient S at paragraph 65a, the Tribunal found paragraph 67b of the Allegation proved.

Paragraphs 67ci, ii and iii of the Allegation

67. You provided treatment to Patient T as outlined at paragraph 66 above:

- c. without the necessary qualifications and training in:
  - i. paediatrics; **Found proved**
  - ii. general practice; **Found proved**
  - iii. clinical management of a minor; **Found proved**

710. Patient T was 11 years old at the time of treatment, and a child, this required specialist paediatric qualifications or those of a general practitioner. Having reviewed the summary of Dr Webberley's career history and qualifications, the Tribunal considered that he did not hold the required specialist qualifications in either paediatrics or as a general practitioner and therefore he was not qualified in the autonomous clinical management of minors.

711. Accordingly, the Tribunal found paragraphs 67ci, ii and iii of the Allegation proved.

#### Paragraph 67d of the Allegation

- 67. You provided treatment to Patient T as outlined at paragraph 66 above:
  - d. whilst failing to adhere to a recognised training pathway in transgender medicine. **Found proved**

712. For the same reason as the Tribunal has set out in relation to Patient S at 65c, the Tribunal found paragraph 67b of the Allegation proved.

#### Patient U

713. Patient U, who had been assigned female at birth, was 22 years old when they first contacted GenderGP by email wanting to transition. At this time Patient U had a significant history of mental illness and was receiving care from their local community mental health team. In March 2017, Patient U was living in a women's refuge and had been admitted to hospital on numerous occasions. Patient U had a complex mental health history including a diagnosis of borderline/emotional unstable personality disorder. They were taking anti-psychotic medication and also anti-depressant medication. Patient U's medical records disclosed a history of numerous attempts at suicide and self-harm. There was also a history spanning a number of years, including a referral to the Nottingham GIDS as a teenager, which Patient U chose not to pursue, of Patient U having expressed confusion about their gender. At the time they contacted GenderGP there had been no formal diagnosis of gender dysphoria.

714. In May 2017, Patient U was living in supported housing for people with mental health problems. At this time Patient U attended their GP and discussed their issues around gender dysphoria and Patient U's desire to undergo gender

reassignment surgery. A GP at the Practice offered to refer Patient U to a GIC in London, but in the event, Patient U decided to contact GenderGP.

715. Patient U first approached GenderGP by email on 9 May 2017. Thereafter, and following completion of an online questionnaire, Patient U underwent a brief 'assessment process' which ultimately resulted in Dr Webberley prescribing cross-sex hormones namely testosterone gel.

#### Paragraph 68a of the Allegation

68. Between May 2017 and July 2018, you failed to provide good clinical care to Patient U in that you:

- a. did not establish an adequate MDT; **Found proved**

716. During the period that Patient U was under the care of GenderGP there were three professionals involved; Dr Webberley, Dr Tilly Storr, who interviewed Patient U and provided a psychological evaluation report and Ms Marianne Oaks, a Counsellor who reviewed Dr Storr's report.

717. Within the psychological report prepared by Dr Tilly Storr, she gave her full title as 'Dr. Tilly Storr, Dip EH.P. NLP (BHR), Dip Couns. (CSCT), MBPS, ASIIP Cert. Supervision'. Dr Kierans was unable to assist as to what the qualifications listed represented although she gave evidence that Dr Storr was not registered with the HCPC which would have been expected had she been a practising clinical psychologist. The Tribunal also noted that, in a document apparently prepared by Dr Webberley during the course of the GMC investigation, he referred to Dr Storr as a consultant clinical psychologist with a PhD. Beyond the fact that the Tribunal was satisfied that Dr Storr was not a medical doctor, it was unable to determine whether Dr Storr met the criteria for mental health professionals as laid down in WPATH guidelines.

718. Similarly, for the reasons given in relation to Patient S, the Tribunal was unable to determine whether Ms Oakes was a qualified mental health professional meeting the criteria in WPATH guidelines.

719. Nevertheless, the Tribunal noted that there was no suitably qualified endocrinologist/gender specialist involved in Patient U's care, it having previously determined that Dr Webberley himself was not suitably qualified in this regard.

720. Further, and in any event, the Tribunal accepted the evidence of Dr Kierans that the management of Patient U's care was performed by Dr Webberley alone. Although there was an initial psychological assessment by Dr Storr in respect of which she provided a report reviewed by Ms Oakes, Patient U's GenderGP records demonstrated that there was no MDT working. There was a notable absence of direct discussion between any of these professionals regarding Patient U, their diagnosis or treatment planning. Accordingly, the Tribunal concluded that there was no adequate MDT established and which, for the reasons previously given in relation to Patient S, there should have been.

721. Accordingly, the Tribunal found paragraph 68a of the Allegation proved.

Paragraphs 68bi and ii of the Allegation

68. Between May 2017 and July 2018, you failed to provide good clinical care to Patient U in that you:

- b. diagnosed Patient U with gender dysphoria on 15 July 2017:
  - i. without any face-to-face or video consultations with Patient U; **Found proved**
  - ii. without receiving any information from Patient U's GP to corroborate information received from Patient U via the online questionnaire completed on 23 May 2017; **Found proved**

722. Given that Dr Webberley had started prescribing cross-sex hormones in June 2017, the Tribunal concluded that Dr Webberley's diagnosis of gender dysphoria must have predated 15 July 2017. However, the Tribunal did not consider that this fact was of any significance in relation to this paragraph. The Tribunal was satisfied that the diagnosis had been made by Dr Webberley at some point after receiving Dr Storr's psychological assessment and before his first prescription of cross-sex hormones to Patient U.

723. In relation to paragraph 68bi, on reviewing Patient U's GenderGP medical records, the Tribunal concluded that at no time during the period over which Patient U was Dr Webberley's patient, did he ever meet Patient U in person or via a video consultation. Indeed, the Tribunal considered that there was no evidence that Dr Webberley had ever spoken to Patient U and that the only communication he had with them was via brief emails.

724. Accordingly, the Tribunal found paragraph 68bi of the Allegation proved.

725. In relation to paragraph 68bii, Patient U completed an online questionnaire on 23 May 2017. Notably, within that questionnaire they did not disclose what, on any view, was a complex mental health history. However, in relation to a question regarding 'current medication', Patient U disclosed that they were taking Risperidone, Sertraline and Zopiclone, a combination of anti-psychotic, anti-depressant and sedative medication. The Tribunal noted from a subsequent email within Patient U's medical record that Dr Webberley had alerted himself to the fact that Patient U was taking this medication.

726. Patient U's GenderGP medical records and the evidence of Dr Wookey, Patient U's GP, confirm that the only communication by Dr Webberley or GenderGP with Patient U's GP was limited to enquiries seeking to establish a shared-care agreement with Patient U's GP. Dr Webberley did not, at any stage, seek to obtain

information from Patient U's GP regarding their state of health either following receipt of the online questionnaire or subsequently.

727. Accordingly, the Tribunal found paragraph 68bii of the Allegation proved.

Paragraphs 68biii1, 2 and 3 of the Allegation

68. Between May 2017 and July 2018, you failed to provide good clinical care to Patient U in that you:

b. diagnosed Patient U with gender dysphoria on 15 July 2017:

iii. based upon psychological assessments from counsellors:

1. who were unregulated; **Found not proved**

2. who had never met Patient U;  
**Found proved**

3. which you should have recognised were insufficiently detailed; **Found proved**

728. In relation to paragraph 68biii1, the Tribunal, for reasons previously stated, were unclear as to the nature or extent of Dr Storr's qualifications and therefore were also unclear as to whether she was registered with any professional regulatory body. With regard to Ms Oakes, the Tribunal had previously observed that she was described as a member of the BACP, the UK regulatory body for counsellors and psychotherapists. In these circumstances, the Tribunal was unable to conclude, on the balance of probabilities, that either of these counsellors were unregulated.

729. Accordingly, the Tribunal found paragraph 68biii1 of the Allegation not proved.

730. In relation to paragraph 68biii2, Patient U's Gender GP medical records demonstrate that, of the two counsellors involved, Patient U had only communicated with Dr Storr, and this was on the occasion of Dr Storr's initial psychological assessment. The Tribunal was satisfied, on the balance of probabilities, that this assessment had been by telephone and was not in person or via video (email correspondence refers to arrangements for a call and correspondence post dating the assessment refer to Patient U not having access to skype). Accordingly, the Tribunal concluded that neither counsellor had met with Patient U.

731. Accordingly, the Tribunal found paragraph 68biii2 of the Allegation proved.

732. In relation to paragraph 68biii3, Dr Kierans characterised the psychological assessment as reflected in Dr Storr's report of her one-off phone call with Patient U as being 'wildly inadequate'. The Tribunal having considered the report agreed

entirely with this description. The report prepared by Dr Storr did not even identify whether her single consultation with Patient U had been in person, was on the phone or was by video link. The extent of the report was essentially a recording of Patient U's narrative with regard to their current situation, childhood, puberty, family, friends and colleagues, presentation and expectations. As to Patient U's complex mental health history, there was a six-line paragraph recording Patient U's own description of her history, which having regard to Patient U's medical records was superficial and incomplete. There appeared to be no examination or exploration by Dr Storr as to what lay behind the brief history related by Patient U. For example, the six-line paragraph concludes with the sentence:

*"He has been seen by a few psychiatrists in the past and this has been helpful. He currently feels positive about the future and is looking forward to progressing his transition".*

733. The Tribunal observed, as had Dr Kierans, that in fact it had been some two weeks prior to the assessment that Patient U had been hospitalised following a deliberate overdose (something that had occurred on some 14 previous occasions in Patient U's life).

734. Dr Storr's report concluded with three paragraphs dealing with 'Concerns / Recommendations'. It simply and shortly dismissed Patient U's mental health difficulties by asserting that which she had been told by Patient U which was that their mental health issues were being addressed by their mental health team:

*"he feels safe and supported, he is aware he can ask for counselling through GenderGP and he would not allow himself to be at risk as he had in the past".*

735. The Tribunal concluded that this report was wholly insufficient in necessary detail and accepted the evidence of Dr Kierans in this regard.

736. Accordingly, the Tribunal found paragraph 68biii3 of the Allegation proved.

#### Paragraphs 68ci and ii of the Allegation

68. Between May 2017 and July 2018, you failed to provide good clinical care to Patient U in that you:

- c. prescribed private prescriptions of Testosterone Gel ('TestoGel') between 28 June 2017 and 30 May 2018, each of eight weeks' supply, which was not clinically indicated in that you:
  - i. had not received relevant information from Patient U's GP; **Found proved**
  - ii. did not communicate with Patient U's mental health workers beforehand; **Found proved**

737. The Tribunal, having found 68bii and iii proved, and for the reasons given, it determined that Dr Webberley's diagnosis of gender dysphoria was not a secure one, as it was based upon an inadequate assessment. This included the fact that Dr Webberley had failed to obtain any information regarding Patient U's medical history, in particular with regard to their mental health, from either Patient U's GP or any mental health workers who had in the past, and were at the relevant time, supporting Patient U.

738. The Tribunal concluded that, in the words of Dr Quinton, Dr Webberley was managing Patient U within an 'information vacuum'. In these circumstances, he should not have been prescribing Patient U testosterone gel during the period alleged to Patient U.

739. Accordingly, the Tribunal found paragraphs 68ci and ii of the Allegation proved.

#### Paragraphs 68di and ii of the Allegation

68. Between May 2017 and July 2018, you failed to provide good clinical care to Patient U in that you:

- d. did not ensure informed consent had been obtained from Patient U in that you:
  - i. only obtained consent remotely and did not allow Patient U the opportunity to engage with you personally to discuss risks and benefits of treatment; **Found proved**
  - ii. inadequately assessed Patient U's understanding of the risks and benefits of treatment in that you only asked them to provide a written summary; **Found proved**

740. The Tribunal acknowledged that Patient U had been sent booklets by email setting out the risks and benefits of testosterone treatment and the monitoring required. However, as the Tribunal had already noted, at no time prior to commencing treatment or subsequently, did Dr Webberley either meet or speak to Patient U and the only communication was via email. The Tribunal considered that even for a patient without a complex mental health history, this would not have been sufficient to ensure informed consent had been obtained. Further, and in any event, the email communication regarding consent and the discussion of the risks and benefits of treatment was limited to an enquiry by Dr Webberley in these terms:

*"Hi, do you have any questions or queries before we go ahead? Will your GP help with prescriptions at all? Do you need any help with ongoing counselling?"*

*I would be grateful if you could give me a detailed summary here of your thoughts and feelings and wishes. Your understanding of hormone treatment and the effects that will happen. The impact this will have on those around you and the impact it will have on you, including thoughts on your fertility. Please give me as much information as you can in one big summary. Please also ask any questions you may have. Best wishes, Dr Webberley”*

741. Although Patient U responded to this email in some detail as to their understanding, the Tribunal noted that Dr Webberley did not respond to Patient U. Rather, within three minutes following receipt of Patient U’s email, Dr Webberley emailed an administrative assistant with instructions to set up a shared care agreement. The Tribunal considered, in any event, that this could not have been sufficient time for Dr Webberley to adequately assess Patient U’s understanding or satisfy himself that informed consent had been obtained.

742. Accordingly, the Tribunal found paragraphs 68di and ii of the Allegation proved.

Paragraphs 68di iii1 and 2 of the Allegation

68. Between May 2017 and July 2018, you failed to provide good clinical care to Patient U in that you:

d. did not ensure informed consent had been obtained from Patient U in that you:

iii. did not inform yourself of Patient U’s involvement with mental health workers, specifically:

1. the mental health workers’ concerns regarding gender affirming treatment; **Found proved**
2. Patient U’s capacity to provide informed consent. **Found proved**

743. The Tribunal had already noted that Patient U had a significant mental health diagnosis of which Dr Webberley would have been aware by reason of Patient U’s answers to the patient questionnaire, which included medication, and Dr Storr’s psychological assessment report. Notwithstanding this, Dr Webberley did not take any steps to inform himself of Patient U’s involvement with mental health workers, both past and current. Had he done so he would have been aware of the ongoing concerns of Patient U’s mental health workers as to the appropriateness of Patient U’s gender affirming treatment, in relation to which the Tribunal had evidence from Patient U’s community mental health nurse, Ms James. Further, despite Dr Webberley’s knowledge of a significant mental health diagnosis, he neither met nor spoke to Patient U himself. In these circumstances, the Tribunal concluded that Dr Webberley could not have properly informed himself of Patient U’s capacity to consent, or that any consent given by Patient U was informed.

744. Accordingly, the Tribunal found paragraphs 68diii1 and 2 of the Allegation proved.

Paragraphs 69a and bi and ii of the Allegation

69. On 21 September 2017, when Patient U was temporarily uncontactable, you failed to:
- a. suspend Patient U's gender-affirming treatment, including administration of TestoGel; **Found proved**
  - b. advise the following that the gender-affirming treatment, including administration of TestoGel, should be suspended:
    - i. Patient U; **Found proved**
    - ii. Patient U's GP. **Found proved**

745. The Tribunal accepted the expert evidence of both Dr Kierans and Dr Quinton that following the initiation of cross hormone treatment, there needs to be ongoing monitoring and review to verify the patients' physical, psychological and social responses to treatment. This was notably absent with regard to Dr Webberley's ongoing care of Patient U. Patient U having commenced treatment in June 2017 with testosterone gel, continued to be prescribed medication through to May 2018. This was despite the fact that, in September 2017, Patient U ceased contact with GenderGP and did not re-engage with them until February 2018 despite repeated emails to from GenderGP to contact during this period. It was at this time Patient U emailed GenderGP explaining that; they had been through "*quite a lot*", and people who Patient U thought had been supporting them were in fact trying to stop them, and that they had been subjected to sexual violence in September 2017 and they had had to be moved for their own safety into an all-female house where they had to stop taking their hormones.

746. The Tribunal accepted the evidence of Dr Quinton that when Patient U ceased communicating with GenderGP, Dr Webberley should have immediately contacted both Patient U and their GP informing both that the gender affirming treatment pathway, including drug treatment should be suspended unless/until their ongoing treatment could be supervised.

747. Accordingly, the Tribunal found paragraphs 69a and bi and ii of the Allegation proved.

Paragraphs 70a and b of the Allegation

70. You continued to prescribe eight weeks' supply of TestoGel to Patient U even though you:

- a. learned that CMHT had previously disagreed with TestoGel treatment; **Found not proved**
- b. had reasons to believe that Patient U was regularly over-dosing on the prescribed TestoGel. **Found not proved**

748. As to this paragraph, the allegation was premised on the assertion that Patient U's GenderGP medical records indicate that; a) NHS community mental health services had disagreed with testosterone treatment in 2017 and, b) that Patient U had been regularly overdosing on the prescribed testosterone. Therefore, the GMC allege that Dr Webberley must have learned of these facts and nevertheless decided to continue to prescribe testosterone. The Tribunal, having reviewed Patient U's GenderGP medical record, were unable to identify any evidence supporting either of these assertions.

749. Accordingly, the Tribunal found paragraphs 70a and b of the Allegation not proved.

#### Paragraphs 71a, b and c of the Allegation

- 71. You provided treatment to Patient U as outlined at paragraph 68 - 70 above:
  - a. outside the limits of your expertise as a consultant gastroenterologist; **Found proved**
  - b. without the necessary qualifications and training in general practice; **Found proved**
  - c. whilst failing to adhere to a recognised training pathway in transgender medicine. **Found proved**

750. The Tribunal has previously given reasons as to the limits of Dr Webberley's qualifications, expertise and failure to adhere to training pathways in transgender medicine. The reasons apply equally in relation to Patient U. The treatment provided by Dr Webberley (namely prescribed testosterone), to Patient U, should only have been provided by a suitably qualified general practitioner, endocrinologist or gender specialist, and on the assumption that there had been a proper assessment process and diagnosis prior to the prescription, either by an MDT or otherwise.

751. Accordingly, the Tribunal found paragraphs 71a, b and c of the Allegation proved.

#### Patient V

752. Patient V was nine years and eight months when Patient V's parents first contacted GenderGP to request puberty blocker treatment on behalf of their child.

753. Patient V had been born a biological girl. However, from a young age Patient V's mother described them as having identified with boys, describing them as a 'tomboy', which in hindsight, her evidence was, she recognised as signs of gender dysphoria. By early 2018, Patient V said to their mother that they were a 'boy', Patient V's eating habits had changed, they had stopped eating desserts and snacks, and they were expressing concern that they were growing 'boobies' and that this was because they were overweight. On being told that they would continue to grow regardless of what they ate, Patient V began showing increasing signs of distress at the prospect of becoming a woman.

754. Following a great deal of research by Patient V's parents into gender dysphoria and having sought advice from 'Mermaids', a charity for trans children, they went with Patient V to their GP hoping for a referral to a GIDS. In due course, Patient V was referred to a GIDS. However, Patient V's parents were informed that there was a five-month waiting list. Following further research by Patient V's parents, they contacted Dr Webberley at GenderGP, as they understood he could provide a 'bridging service' whilst Patient V was on the waiting list.

755. Patient V's parents first contacted Dr Webberley at GenderGP by email on 17 May 2018.

#### Paragraph 72a of the Allegation

72. Between May 2018 and October 2018, you failed to provide good clinical care to Patient V in that you:

a. did not establish an adequate MDT; **Found proved**

756. In relation to paragraph 72a, the Tribunal had already determined in relation to other patients, and for the reasons given, that the provision of good clinical care did require there to be the establishment of an adequate MDT. The Tribunal considered that whereas there might be circumstances in which good clinical care could be given otherwise than within the context of an MDT, such circumstances had not existed in the current case by reason of the fact, as the Tribunal had already determined, Dr Webberley lacked the necessary qualification, training or experience to provide such care autonomously, whether with or without the input of other professionals.

757. The Tribunal determined that there needed to be a MDT in relation to the care provided to Patient V for the same reasons as it had set out in relation to other patients. Furthermore, the Tribunal noted that Patient V was nine years old at the time contact was first made with Dr Webberley. The Tribunal considered that this fact alone did not impact on the necessity or otherwise of the establishment of an adequate MDT, or whether Patient V should have been receiving the type of treatment that Dr Webberley was providing.

758. The Tribunal noted that neither Dr Quinton nor Dr Kierans had experience of a child under ten receiving puberty blocker treatment for gender dysphoria. Also, the Tribunal took judicial notice of the fact that in the *Quincy Bell v The Tavistock*

and *Portman NHS Foundation Trust & Others [2020] EWHC 3274 Admin* judgement, reference was made to the youngest age at which the Tavistock GIDS had provided treatment to a child was ten years old. However, the Tribunal, did not consider that chronological age was determinative as to whether puberty blocker treatment should be provided to a patient diagnosed with gender dysphoria. Rather, the Tribunal accepted the evidence of both Dr Quinton and Dr Kierans, that the key pre-requisites before puberty blocker treatment should be provided, are whether the patient concerned has reached, and had an opportunity to experience for a period of time, Tanner stage 2 of pubertal development, whether the patient is *Gillick* competent and able to give informed consent. The age of the patient would usually have a bearing on whether these two criteria are met, but in the Tribunal's judgement, they would not be determinative.

759. Nevertheless, the younger the patient, the less likely it is that they will have reached and experienced Tanner stage 2 or will have sufficient maturity to be *Gillick* competent. Accordingly, the greater the care required in assessment and, in the Tribunal's judgement, the more obvious the need for input from a paediatric endocrinologist / gender specialist and a paediatric mental health professional who has the necessary experience not only in gender dysphoria but also in gender development.

760. In the present case there was no paediatric endocrinologist/ gender specialist input and the only input from 'mental health professionals', were Ms Marianne Oakes and Ms Jayne Olden. The Tribunal had previously observed that the nature of the qualification and experience of these two individuals, on the evidence before it, was uncertain, although the Tribunal noted that in email correspondence Dr Webberley made reference to an assessment being made by one of 'our child psychologists'.

761. However, the Tribunal considered that even if one of these individuals had the necessary qualification, training and experience in child psychology, there was no evidence to support the conclusion that there was a functioning MDT involved in Patient V's care. Although there were records of emails passing information between these individuals and Dr Webberley, there was no record of any discussion about the patients' presentation, nor any joint treatment planning or decision making, neither was there any evidence of the same, in relation to other medical professionals, outwith GenderGP, for example Patient V's GP beyond the provision of ongoing shared care, or the GIDS Patient V had been referred to.

762. Finally, the Tribunal had regard to what appeared to be a note prepared by Dr Webberley in relation to the care provided to Patient V by GenderGP which was sent to the GMC during the course of their investigation. Within that note the members of the MDT are named and three consultant clinical psychologists are referred to, none of them are described as paediatric psychologists and, more importantly, none of them were involved in the care of Patient V. In the same list of MDT members Ms Oakes is described as Lead Counsellor and psycho/gender therapist BACP and Ms Olden as Counsellor and psycho/gender therapist BACP.

763. Accordingly, the Tribunal found paragraph 72a of the Allegation proved.

Paragraphs 72bi and ii1 and 2a of the Allegation

72. Between May 2018 and October 2018, you failed to provide good clinical care to Patient V in that you:
- b. diagnosed Patient V as suffering from gender dysphoria in July 2018:
    - i. based upon a questionnaire which was inadequate for assessment of a minor; **Found proved**
    - ii. without performing an adequate:
      - 1. mental state examination; **Found proved**
      - 2. physical examination; **Found proved**

764. The Tribunal noted that Patient V's mothers' first contact with GenderGP was on 17 May 2018, when she sent an email in which she gave a brief history of Patient V's history of identification as a boy since early childhood and describing Patient V as having started to change since the onset of puberty, becoming extremely distressed as breasts started to show. Patient V's mother concluded the email:

*"We are desperate to get him on hormone blocker as soon as possible, as we can see his mood shifting rapidly. We have bought some chest binders, but they are very restrictive and not a solution."*

765. Dr Webberley replied the same day:

*"...very happy to help you and [Patient V] (why do they have to start puberty so young....!)*

*We have a process to go through and one of the big things we need to solve is 'who will actually inject the blockers?' Is your GP on board and helpful?"*

766. The Tribunal accepted the evidence of Dr Kierans that the assessment and diagnosis of gender dysphoria in children requires a process of careful and detailed evaluation that will ordinarily take place over at least a period of 6-12 months and often longer. Furthermore, the Tribunal accepted that even where a diagnosis of gender dysphoria was made in respect of a child, treatment by means of puberty blockers represents but one treatment pathway.

767. In these circumstances, the Tribunal regarded it as striking that Dr Webberley's first email appeared to anticipate puberty blocker treatment before he could possibly have known that a diagnosis of gender dysphoria was appropriate or indeed treatment by puberty blockers would be clinically indicated. The Tribunal considered that this email evidenced anticipation on Dr Webberley's part that a

prescription would in due course be made and, would no doubt, have given Patient V's parents and Patient V this expectation.

768. As to the assessment, which in due course took place, and which resulted in a prescription of puberty blockers on 16 July 2018, this was limited to the completion of two online questionnaires (one said to be for adults and one said to be for under sixteens), a consultation with Ms Oakes and Patient V and the parents and a skype consultation with Dr Webberley on 16 July 2018 which only lasted 20 minutes.

769. The online questionnaires were completed by Patient V's mother on behalf of Patient V. The Tribunal accepted Dr Kierans' evidence that it was not in a format in which the questions, or answers to be given, were tailored to Patient V's age or likely level of understanding. Indeed, this was apparent from the fact that in responding to the questionnaires, Patient V's mother stated:

*"\*I read the questions to him, when he interpreted some from his child point of view, I just put the answers as he gave them.\*"*

*\*When a question was not relevant to him, I took the liberty not to ask him and wrote N/A as an answer.\*"*

770. With regard to the single consultation with a counsellor, Ms Oakes, the Tribunal considered that they recorded a superficial exploration into Patient V's feelings and attitudes towards his gender and the Tribunal accepted Dr Kierans' evidence in this regard. There should have been a far greater exploration of Patient V's understanding and views of, amongst other matters, puberty and those factors which were causing him distress. This would not have been for the purpose of attempting to divert Patient V from treatment but to ensure that any treatment provided in the future was in Patient V's best interest and clinically indicated.

771. Furthermore, the Tribunal noted that the only time that ASD appeared to have been considered was in relation to the question *"are you on the Autistic/Asperger's Spectrum"*. The Tribunal accepted that, given the significant correlation between distress about gender and ASD, that all children presenting with gender distress should be screened for ASD. This was not to preclude individuals with ASD from gender affirming treatment, rather it was to ensure that all their needs were considered and integrated into an appropriate treatment plan. The Tribunal accepted that Ms Oakes' assessment did not appear to have included a developmental history which could rule out the presence of ASD or other relevant neurodevelopmental conditions.

772. The Tribunal noted that Ms Olden's involvement in the assessment process was limited to a review of Ms Oakes' assessment which she signed off, having wrongly recorded that Patient V was aged 12 with *'no concerns'* to note.

773. With regard to the skype consultation with Dr Webberley on 16 July 2018, this occurred in circumstances where there was no record of Dr Webberley having discussed Ms Oakes' assessment of Patient V with his colleagues, much less having

agreed a diagnosis or considered treatment alternatives in the light of the same. It was following this short remote consultation, Dr Webberley actually having spoken to Patient V for only ten minutes, that he decided to embark upon hormone blocker treatment.

774. The evidence of Patient V's mother was that this latter consultation lasted 20 minutes. In the first ten minutes of the call Dr Webberley asked Patient V about how they felt and how they envisaged the future, their current life, their feelings about having transitioned at school and about their new name. In the following 10 minutes Patient V's mother discussed with Dr Webberley how things had evolved since Patient V's transition. At the conclusion of the consultation Dr Webberley told Patient V's mother that the best option for Patient V was to start hormone blockers and he issued a prescription that day. In Dr Webberley's record of the consultation, he stated:

*"...[Patient V's mother] told me that [Patient V] has developed hair in the axillae/groin/and legs and that breasts are developing (left larger than right and visible under clothes now. He is also going through a growth spurt. He is clearly in Tanner 2 at least. I explained that I felt that intimate examinations were entirely unnecessary and [Patient V's mother] said that she thought that [Patient V] would find it distressing. Both parents are very concerned that puberty is accelerating and that it needs to be blocked immediately before significant harm occurs. Menstruation has not yet commenced. I firmly believe that GnRHa should be started immediately to halt puberty and buy time for further assessments as necessary. On the balance of risk versus harm, treating this child is the correct thing to do. If puberty is allowed to progress further there is a very real risk of self-harm and mental health issues..."*

775. The Tribunal noted Dr Webberley's reference to the need to commence treatment urgently in order to prevent significant harm occurring and his concern that there was *"a very real risk of self-harm and mental health issues"*. The Tribunal acknowledged and accepted the evidence of Dr Kierans that transgender individuals (both adults and children/adolescents) were a cohort of individuals who were at an increased risk of mental health distress and self-harm. However, as was the evidence of Dr Kierans, there was nothing in Patient V's case to suggest that there were any particular identified risks in this regard. The Tribunal noted that Patient V's mother had expressed concern regarding his mental health without puberty blockers to halt his female puberty, however beyond this fact and Dr Webberley's apparent view that children with gender dysphoria are, in general, at risk without treatment, it considered that there was no evidential basis for this concern in Patient V's case.

776. Finally, there was no physical examination of Patient V, which there should have been in order to establish the Tanner stage of pubertal development. Rather, Dr Webberley relied upon Patient V's mothers' description of his physical development.

777. Accordingly, the Tribunal found paragraphs 72bi and ii1 and 2a of the Allegation proved.

Paragraphs 72ci, ii, iii, iv, v and vi of the Allegation

72. Between May 2018 and October 2018, you failed to provide good clinical care to Patient V in that you:
- c. started to prescribe GnRH-antagonist ('GnRHa') injections off-licence to Patient V on ~~18 July 2018~~ 16 July 2018 without;
    - i. blood test results to confirm biochemical puberty; **Found proved**
    - ii. arranging a baseline bone density scan; **Found not proved**
    - iii. considering alternative treatments; **Found proved**
    - iv. being able to adequately assess the balance between the risks and benefits of prescribing GnRHa to Patient V; **Found proved**
    - v. adequately advising of the risks to Patient V's parents; **Found proved**
    - vi. informing Dr K, Patient V's GP; **Found proved**

778. In relation to paragraph 72ci, given that puberty blocker treatment should not be initiated until the child patient has, at the very least, reached Tanner stage 2 of pubertal development, such treatment should not be initiated until the patient's stage of pubertal development has been determined. The development of Tanner stage 2 was a clinical diagnosis normally ascertained through direct physical examination of characteristic clinical features of this stage of pubertal development.

779. In Dr Quinton's opinion, when a patient was as young as Patient V (nine years old) who was being considered for GnRHa treatment for blocking puberty, then the accurate staging of puberty was of particular importance. However, even if a blood test to establish biochemical puberty was not strictly necessary in addition to a direct physical examination, the Tribunal determined that, having failed to ensure that Patient V had been physically examined, Dr Webberley should have established Patient V's stage of puberty by other means, namely, a blood test.

780. Accordingly, the Tribunal found paragraph 72ci of the Allegation proved.

781. In relation to paragraph 72cii, Dr Quinton gave evidence, that in his opinion, GnRHa treatment for the purposes of halting puberty in children/adolescents may have risks associated with it in the long term with regard to bone density and skeletal development and, to this extent should not be regarded as fully reversible.

Hence, it was his evidence that baseline bone density scans should be performed prior to initiating GnRHa treatment for the purpose of future monitoring of treatment. Indeed, Dr Quinton gave evidence that bone density scans form part of the NHS protocol prior to the initiating of GnRHa treatment.

782. However, with respect to the risks identified by Dr Quinton, the Tribunal had regard to material before it, from a range of sources, in which GnRHa treatment for halting puberty is described as 'fully reversible'. In particular, the Tribunal gave consideration to the WPATH guidelines on this issue and in which there was no mention of the risks identified by Dr Quinton. In these circumstances, whilst the Tribunal acknowledged Dr Quinton's opinion, in the light of the WPATH guidelines, where there were no references to the risks identified by Dr Quinton, and other sources, it did not consider that Dr Webberley could be criticised for failing to arrange bone density scans prior to treatment.

783. Accordingly, the Tribunal found paragraph 72cii of the Allegation not proved.

784. In relation to paragraph 72ciii, as the Tribunal has already observed, it was Dr Kierans' evidence, which the Tribunal accepted, that even where a diagnosis of gender dysphoria has been made, it would not necessarily lead to the prescription of puberty blockers and that there are other treatment pathways which should be considered. This might include continued monitoring (further exploration of their gender identity) and/or counselling.

785. The Tribunal determined that there was no evidence that Dr Webberley had considered any alternatives to puberty blockers. Indeed, his first email to Patient V's initial enquiry, in the Tribunal's judgement, indicated that he had a closed mind as to other alternatives.

786. Accordingly, the Tribunal found paragraph 72ciii of the Allegation proved.

787. In relation to paragraph 72civ and v, the Tribunal had already found that the assessment process of Patient V had been inadequate. Indeed, in the Tribunal's judgement it was wholly inadequate for the purpose of either diagnosing gender dysphoria or establishing whether puberty blocker treatment was indicated or, whether alternative treatment pathways should have been considered. In these circumstances, the Tribunal concluded that it would not have been possible for Dr Webberley to either adequately assess the balance of risk and benefit of prescribing GnRHa, or adequately advise Patient V's parents in relation to the same.

788. Accordingly, the Tribunal found paragraph 72civ and v of the Allegation proved.

789. In relation to paragraph 72cvi, The Tribunal accepted the evidence of Dr King, Patient V's GP, that she/her Practice had initially been contacted with a view to entering into a shared-care agreement which would have involved the prescription of puberty blockers which Dr King's Practice which was declined. Dr Webberley did not inform Dr King when he himself started prescribing Patient V. It was only after prescribing, that Dr Webberley informed Dr King and/or her Practice. Given that Dr

Webberley had been in communication with the GP Practice with regard to Patient V's care, and he had permission to do so, the Tribunal determined that he should have informed Dr King/her Practice before starting GnRHa treatment with regard to Patient V's care. This was particularly so given that Patient V was a nine-year-old child who was to embark upon puberty blockers to arrest their puberty.

790. Accordingly, the Tribunal found paragraph 72cvi of the Allegation proved.

Paragraph 72d of the Allegation

72. Between May 2018 and October 2018, you failed to provide good clinical care to Patient V in that you:

d. continued to prescribe GnRHa to Patient V without first conducting a period of assessment over several months;

**Found proved**

791. Despite Dr Webberley having performed an inadequate assessment of Patient V before commencing the prescription of GnRHa to Patient V and having started the treatment because it was his 'firm belief' that puberty should be halted immediately and that this would "*buy time for further assessments as necessary*", there were no further assessments, consultations or reviews whilst Patient V remained Dr Webberley's patient (October 2018). The Tribunal accepted the evidence of Dr Kierans that, not only should there have been assessment prior to prescription, but there should have been further assessment and a direct review of Patient V's response to treatment.

792. Accordingly, the Tribunal found paragraph 72d of the Allegation proved.

Paragraphs 72ei, ii and iii of the Allegation

72. Between May 2018 and October 2018, you failed to provide good clinical care to Patient V in that you:

e. did not obtain informed consent from Patient V in that you:

i. did not adequately assess Patient V as being Gillick competent; **Found proved**

ii. in the alternative to Paragraph 72e.i, did not record how you reached the conclusion that Patient V was Gillick competent; **Found not proved**

iii. failed to discuss the full risks and benefits of treatment with Patient V directly; **Found proved**

793. Following Dr Webberley's skype consultation with Patient V and his mother, he recorded that:

*“[Patient V] has capacity to consent to his now treatment and fully understands the pros and cons. He is Gillick competent. Both parents are supportive.”*

794. This was the extent of Dr Webberley’s direct reference to issues surrounding capacity and competence in relation to a nine-year-old child who he was to prescribe, that same day, puberty blockers for the treatment of gender dysphoria, which Dr Webberley had himself diagnosed.

795. Despite the assertion in Dr Webberley’s note of consultation, the Tribunal determined that he could not and had not, performed an adequate assessment of Patient V’s Gillick competence. Patient V’s medical records and the evidence of Patient V’s mother demonstrated; Patient V did not fully understand the questions that were being asked of him, Patient V’s mother had not asked some of the questions because she did not consider they were relevant to Patient V by reason of his age and understanding. During Ms Oakes’ consultation with Patient V she noted that he was very shy and *‘it was difficult to say what his expectations’* were, she also observed that Patient V’s mother did a lot of the talking on his behalf. Dr Webberley’s skype consultation, limited to ten minutes with Patient V (notably, in the presence of his mother and not alone) represented the entirety of his direct communication with Patient V.

796. In these circumstances, the Tribunal accepted Dr Kierans’ evidence that assessing competence and obtaining of informed consent with children/adolescents, is a process which necessarily takes time and several discussions. This is required to enable the patient to demonstrate their understanding, their ability to retain information, to reflect, ask questions, and importantly, to give them the opportunity to change their mind.

797. In the Tribunal’s judgement, the manner and, time over which, Dr Webberley conducted this process made it impossible for Patient V to be adequately assessed as being Gillick competent or give informed consent. Further, because of the inadequacy of the assessment process as a whole and the shortness of his consultation with Patient V, Dr Webberley could not have fully discussed the risks and benefits of treatment with Patient V and ensured their understanding.

798. The Tribunal considered that an analysis of Patient V’s medical record demonstrated in numerous respects the significant shortcomings in the assessment process including failures to explore with Patient V the issues surrounding his ‘gender dysphoria’, the proposed treatment and the relative risks and benefits and which were described by Dr Kierans.

799. However, the Tribunal considered that there was one example that was illustrative of the point. Nowhere within Patient V’s medical record was there any evidence that Dr Webberley, or Ms Oakes, had discussed with him issues surrounding future fertility and reproduction. The Tribunal was only able to identify one reference relevant to this issue.

800. In a questionnaire the following question was asked:

*“Cross-sex hormone therapy can impact on your future fertility. Please let us know your thoughts around fertility and your plans for this.”*

801. Patient V’s mother answered on Patient V’s behalf:

*“\*As a 9 year old [Patient V] doesn’t have a clear insight into his future feelings around fertility. However since he was very small, he has always said that there was no way he would ever want a baby in his tummy and would adopt.\*”*

802. The Tribunal considered that this fell far short of an adequate explanation of the potential impact that treatment might have on future fertility and/or discussion of the same with the patient in terms that they will understand.

803. In the Tribunal’s judgement, Dr Webberley’s failure to discuss and ensure understanding of issues surrounding fertility was significant. Dr Kierans’ evidence was that although GnRHa treatment is reversible and therefore does not directly impact upon future fertility in either boys or girls, it is nevertheless important to give consideration to fertility issues before initiating puberty blocker treatment. The reasons for this are numerous, not least because puberty blocking medication may set the patient on a pathway towards gender affirmation treatment (through prescription of cross-sex hormones). Also, fertility is not immediately restored upon the cessation of puberty blockers (if the patient were not to proceed to change their biological gender, or if they wished to harvest/store their eggs/sperm). It was Dr Quinton’s evidence that GnRHa induced fertility and anovulation in a natal female would be expected to resolve or revert to baseline within 6-12 months of discontinuing a long-acting treatment.

804. Accordingly, the Tribunal found paragraphs 72ei and iii of the Allegation proved. In respect of paragraph 72eii, the alternative did not arise, and the Tribunal found it not proved.

#### Paragraphs 72fi, ii and iii of the Allegation

72. Between May 2018 and October 2018, you failed to provide good clinical care to Patient V in that you:

- f. did not obtain informed consent from Patient V’s parents on 29 June 2018 in that:
  - i. you obtained consent for testosterone treatment seven years before Patient V could receive it;  
**Found not proved**
  - ii. you did not counter-sign the leaflet provided to Patient V’s parents detailing the intended treatment (‘the Leaflet’); **Found not proved**

- iii. the Leaflet incorrectly advised that hormone blockers are fully reversible; **Found not proved**

805. In relation to paragraph 72fi, The Tribunal considered the terms of the consent form, concluded that this allegation was based on a false premise. The form did not consent for testosterone treatment seven years before Patient V could receive it (by being 16 years old). Rather, the form explained that testosterone would not normally be prescribed before the patient was 16 years old but there might be exceptional circumstances in which testosterone could be prescribed before aged 16. The form further explained that in the event of these circumstances arising, the prescription of testosterone would be at the discretion of the supervising doctor in discussion with the patient and their family.

806. Accordingly, the Tribunal found paragraph 72fi of the Allegation not proved.

807. 72fii and iii, for reasons previously given in respect of other patients, both androgen and transgender patients, the Tribunal did not consider the absence of a counter signature by Dr Webberley meant that informed consent had not been given.

808. With regard to 72fiii and for the reasons previously given in respect of this patient, the Tribunal determined that advice that hormone blockers are fully reversible could not be regarded as incorrect in the light of WPATH guidelines and other sources which refer to this treatment as being reversible.

809. Accordingly, the Tribunal found paragraphs 72fi, ii and iii of the Allegation not proved.

Paragraphs 72gi1 and 2, ii, iii1, 2, 3 and 4, iv1 and 2, v1 and 2 of the Allegation

72. Between May 2018 and October 2018, you failed to provide good clinical care to Patient V in that you:

- g. provided information ('the Information') to Patient V's parents which:
  - i. failed to declare:
    - 1. your lack of qualifications to manage the care of minors; **Found not proved**
    - 2. that Dr HW was no longer a credible MDT member as she was subject to an interim order of suspension; **Found not proved**
  - ii. detailed an inadequate MDT make-up; **Found not proved**
  - iii. stated that:

1. GnRHa was required to entirely prevent the onset of puberty in suspected transgender minors, which is contrary to expert guidance; **Found not proved**
  2. there was a 50% risk of attempted suicide in young transgender clients, which was not based upon UK statistics; **Found not proved**
  3. Dr TS was a Consultant Clinical Psychologist, when she was a qualified counsellor; **Found not proved**
  4. Dr VP was a Consultant Clinical Psychologist, when she was a registered Counselling Psychologist; **Found not proved**
- iv. made incorrect statements about NHS transgender services, including that:
1. the ‘minimum expected wait for treatment is likely to be five and a half years’; **Found not proved**
  2. as a consequence of delay, transgender minors would necessarily require more extensive surgery in the future; **Found not proved**
- v. incorrectly advised that:
1. hormone blockers were ‘fully reversible’; **Found not proved**
  2. testosterone could be prescribed to patients under 16 in exceptional circumstances. **Found not proved**

810. The Tribunal, having considered the allegations contained within paragraph 72gi-v and Dr Quinton’s evidence, concluded that the information which Dr Webberley was alleged to either failed to give Patient V’s parents, or which he had incorrectly given, had not been given to Patient V’s parents, rather the ‘Information’ was that contained within a document at the beginning of Patient V’s medical records which the Tribunal had been informed by Mr Jackson had been provided by Dr Webberley to the GMC during the course of their investigation, and in respect of which Dr Webberley appeared to have been the author and, in which he explained GenderGP’s involvement in Patient V’s care.

811. In these circumstances, the Tribunal determined that the stem of 72g was misconceived, the 'Information' had not been to Patient V's parents rather it had been provided to the GMC.

812. Accordingly, the Tribunal found paragraphs 72gi1 and 2, ii, iii1, 2, 3 and 4, iv1 and 2, v1 and 2 of the Allegation not proved.

#### Paragraphs 73a and b of the Allegation

73. The distribution of the Information was:
- a. done in order to persuade Patient V's parents to use Gender GP for the care and treatment of Patient V; **Found not proved**
  - b. financially motivated. **Found not proved**

813. The Tribunal determined that this allegation was based upon the same misconception as paragraph 72, namely the 'Information', was not distributed to Patient V's parents.

814. Accordingly, the Tribunal found paragraphs 73a and b of the Allegation not proved.

#### Paragraph 74a of the Allegation

74. You provided treatment to Patient V as outlined at paragraph 72 above:
- a. outside the limits of your expertise as a consultant gastroenterologist; **Found proved**
  - b. without the necessary qualifications and training in:
    - i. paediatrics; **Found proved**
    - ii. general practice; **Found proved**
    - iii. clinical management of a minor; **Found proved**
  - c. whilst failing to adhere to a recognised training pathway in transgender medicine. **Found proved**

815. The Tribunal found paragraph 74a, b and c proved for the same reasons as in paragraph 67b, ci, ii and iii and 67d in respect of Patient T, who was also a child patient who was prescribed puberty blockers by Dr Webberley.

816. The Tribunal considered it appropriate to acknowledge and record the fact that, despite those allegations it has found proved, the Tribunal accepted the evidence of Patient V's mother that in her view, since commencing hormone

blocking treatment, Patient V returned back to his 'happy self'. Although she stated he still experiences gender dysphoria, her son's mental health had been preserved and her evidence was that she did not know *'where we would be without the timely help of Dr Webberley. The alternative we had, no help at all, is not worth thinking about'*. The Tribunal accepted that Patient V had not been seen by the GIDS to which he had been referred in a timely manner, and that it was this fact that had led Patient V's parents to seek care for their child privately. On the evidence before the Tribunal, it considered that the delays Patient V encountered were not unique and had been experienced by others in similar circumstances.

### **Patient W**

817. The Tribunal had what was obviously an incomplete copy of GenderGP's medical records in respect of Patient W, comprising; information leaflets, consent forms, some blood test results, copy identity documents and a shared care agreement together with related correspondence with Patient W's GP. The remaining evidence relating to Patient W's care was limited to a statement from Patient W's father, Patient W's GP, Dr Yu, a statement from Dr Webberley provided to a coroner who conducted an inquest into the circumstances of Patient W's death in September 2018, and Patient W's NHS GP medical records.

818. Due to the incomplete GenderGP records and the paucity of documents from GenderGP relating to Patient W's care, the GMC's case in relation to the allegations at paragraphs 75-76 relied substantially upon inferences that the GMC submitted could be drawn from the other evidence.

819. Dr Webberley's statement to the coroner recorded that Patient W first made contact with him/GenderGP on 19 June 2018, at the age of 17.8 years. Patient W reported that he had been on the GIDS waiting list for eleven months, but he had then been told he was too old to be seen and so his referral was going to be passed onto an adult referral waiting list, in which the waiting time was going to be up to two years. In this email Patient W stated they really needed to start on FTM (female to male) hormones as soon as possible and could not wait any longer.

820. Dr Webberley stated that he had an initial consultation with Patient W on 25 June 2018. It is unclear whether this consultation was in person or over skype/telephone. Patient W's father believed that on the occasions that Patient W spoke to Dr Webberley it would be over skype. Dr Webberley's note of the consultation recorded the following:

*"Age 17 (nearly 18) 8 Sept FtM  
For a very long time has wanted testosterone  
since about 4 years old  
Out for about 3 years to family and friends  
Was on Tavi waiting list but too old and now waiting for adult services  
GP checking on the referral  
No real surprise to parents although shocked initially  
Very well supported  
Has been really very unhappy at school and during puberty*

*Always has had knowledge that he was male but didn't know what it was called  
Teachers and classmates all know and very well accepted  
Not interacted with trans groups  
Done a lot of research  
GP likely to be supportive  
I have no doubt that we can help Jess achieve his goals  
Asked parents to email in"*

821. Dr Webberley stated that he received a further email from Patient W on 3 July 2018 which stated:

*"When I was 16 i went to my gp (with my mom) asking to be put on the nhs list for Tavistock. I have had no help at all since because the nhs have such ridiculously long waiting lists.'*

*'I currently feel extremely unhappy and impatient. I have waited long enough, I feel like I'm loosing my life the longer I'm not on hormones. I want to medically transition fully as soon as I can.'*

*'I do not need help with any counselling ..... I understand the effects of testosterone and that there are physical, emotional, sexual and reproductive changes. I understand that some of these changes are permanent even after stopping hormones....., I think it will have a good effect on everyone around me as it will make it easier for people to gender me correctly so they will make less mistakes. It will have such a massively positive impact on my own mental health.'*

*'I have been waiting to go on hormones so long now and it means so much to me. I am so happy it is finally happening."*

822. Neither the notes of Dr Webberley's consultation or the emails from Patient W referred to in the statement to the coroner were contained within Patient W's GenderGP records that were available to the Tribunal.

823. The first entry in Patient W's GP notes regarding Dr Webberley appeared on 6 July 2018. This recorded that bloods had been taken as per Dr Webberley's instruction. Patient W's GP, Dr Yu's evidence was that this would have been carried out because the Practice would have received a letter from Dr Webberley/ GenderGP requesting bloods.

824. On 19 July 2018 Patient W's GP Practice received a fax from GenderGP of a shared-care protocol inviting the Practice to agree to a protocol for the provision of blood testing and prescription under supervision by Dr Webberley. Patient W's GP, Dr Yu responded and agreed to enter into a shared-care agreement.

825. Due to the absence of any GenderGP medical records, there was no evidence as to whether Dr Webberley himself prescribed cross-sex hormones to Patient W. Patient W's father's evidence was that a couple of months before Patient W's death (end of September 2018), Patient W started receiving packages from the chemist which Patient W's father assumed to be medication, but he did not know what.

Paragraphs 75ai, ii, ii1 and 2 of the Allegation

75. Between June 2018 and September 2018, you failed to provide good medical care to Patient W in that you:
- a. diagnosed Patient W with gender dysphoria and did not:
    - i. establish an adequate MDT; **Found proved**
    - ii. carry out any face-to-face consultations with Patient W; **Found not proved**
    - iii. carry out an adequate:
      - 1. physical examination; **Found not proved**
      - 2. mental state examination; **Found proved**

826. In relation to paragraph 75ai, the Tribunal was mindful of the absence of complete GenderGP medical records and, therefore the absence of direct evidence as to whether there were other medical professionals involved in the assessment and subsequent diagnosis of Patient W beyond Dr Webberley himself, whether working as part of a MDT, properly so called, or otherwise.

827. However, the Tribunal had regard to the chronology of events as appeared from the evidence that was available. Briefly stated, initial contact by Patient W with Dr Webberley was on 19 June 2018, followed by consultation with Dr Webberley on 25 June 2018. Thereafter, an email from Patient W to Dr Webberley concluding with:

*"I have been waiting to go on hormones so long now and it means so much to me. I am so happy it is finally happening."*

828. Then on 6 July 2018 Dr Webberley/GenderGP contacted Patient W's GP requesting bloods. In July 2018 Patient W was receiving packages of medication from a chemist. On 19 July 2018 Patient W's GP received a fax from Dr Webberley inviting the practice to enter into a shared care agreement.

829. The Tribunal considered that, in the light of this short chronology, Patient W's email of 3 July 2018 that suggested a decision had already been made to prescribe cross-sex hormones and subsequent events demonstrating hormones had been prescribed during July 2018, it was inherently unlikely that an assessment had been made involving any other professionals.

830. Furthermore, and more particularly, the Tribunal considered that Dr Webberley would have detailed the involvement of other professionals in the care provided to Patient W, in the period between his first contact in June and Patient W's death in September 2018, in the statement he provided to the coroner, if other professionals had been involved in Patient W's care either as members of an MDT or otherwise.

831. In these circumstances, the Tribunal determined that it was more likely than not that an adequate MDT was not established prior to Patient W's diagnosis of gender dysphoria.

832. Accordingly, the Tribunal found paragraph 75ai of the Allegation proved.

833. In relation to paragraph 75aii and 75aiii1, the evidence as to whether Dr Webberley's consultation(s) with Patient W was in person, over skype and/or telephone was unclear, although the Tribunal considered, in the light of the evidence of Patient W's father, that it was probably over skype. In the Tribunal's judgement, if this was the case, it could properly be regarded as a face-to-face consultation. Indeed, neither Dr Quinton nor Dr Kierans suggested that consultations should necessarily have been conducted in person.

834. Similarly, neither of the experts suggested that in relation to the case of Patient W that there should have been a physical examination. The Tribunal also noted that unlike other trans patients it had considered, Patient W was almost 18 years old, he was not a child, and therefore issues regarding the stage of pubertal development that Patient W had reached would not have been expected. Therefore, the Tribunal concluded that a physical examination would not necessarily have been required in his case.

835. Accordingly, the Tribunal found paragraphs 75aii and 75aiii1 of the Allegation not proved.

836. In relation to paragraph 75aiii2, Patient W's NHS GP medical records show that he had a complex psychiatric history. In June 2008, when 7 years old, Patient W had been diagnosed with Asperger's Syndrome, there had been referrals to CAMHS, and in later years a significant history of self-harming behaviour and involvement with medical and mental health professionals with regard to the same.

837. It did not appear that Dr Webberley was aware of these long-standing mental health issues. Despite having been in communication with Patient W's GP with regard to shared care, he had not sought to obtain copies of Patient W's medical records or contact Dr Yu to establish Patient W's medical history. It was the evidence of Dr Yu that he could not recall whether he had informed GenderGP or Dr Webberley of Patient W's mental health issues, but he confirmed that there was nothing in Patient W's notes to record that this had happened. Furthermore, there is no mention in Dr Webberley's initial consultation notes or Patient W's emails as recorded in Dr Webberley's statement to the coroner to suggest that Dr Webberley had been made aware of Patient W's mental health issues.

838. The Tribunal accepted the evidence of Dr Quinton and Dr Kierans that generally, and particularly in the light of Patient W's significant psychiatric history, a mental state examination should have been conducted. The Tribunal considered it more likely than not that there had been no such mental state examination conducted by Dr Webberley because, if there had been, the Tribunal considered that he would have referred to it in his statement to the coroner. Indeed, Dr Webberley's note of his consultation with Patient W in the statement Dr Webberley gave to the coroner suggested that no consideration had been given to Patient W's mental health history.

839. Accordingly, the Tribunal found paragraph 75aiii2 of the Allegation proved.

Paragraphs 75aiv1, 2 and 3, and 75av1, 2 and 3 of the Allegation

75. Between June 2018 and September 2018, you failed to provide good medical care to Patient W in that you:

- a. diagnosed Patient W with gender dysphoria and did not:
  - iv. corroborate any of the information provided to you by Patient W with:
    - 1. Patient W's GP, Dr GY; **Found proved**
    - 2. Patient W's mental health workers;  
**Found proved**
    - 3. the nurse at Patient W's school;  
**Found proved**
  - v. seek further information regarding Patient W's mental health from:
    - 1. Dr GY; **Found proved**
    - 2. Patient W's mental health workers;  
**Found proved**
    - 3. the nurse at Patient W's school;  
**Found proved**

840. The Tribunal, having identified that Patient W's NHS GP records demonstrated a longstanding history of his involvement with mental health workers and staff, including nursing staff, at Patient W's school, concluded that this history should have been explored by Dr Webberley. Had it been, it would have been highlighted to Dr Webberley that a mental state examination was most definitely required in this case. This should have been in addition to seeking information and

records from Patient W's GP. Given Patient W's history it was not sufficient for Dr Webberley to simply rely upon that which his patient had reported to him.

841. The Tribunal determined that Dr Webberley had not contacted, or sought information from either Patient W's GP, previous mental health workers or staff at Patient W's school.

842. Accordingly, the Tribunal found paragraphs 75aiv1, 2 and 3, and 75av1, 2 and 3 of the Allegation proved.

Paragraphs 75bi, ii, iii and iv of the Allegation

75. Between June 2018 and September 2018, you failed to provide good medical care to Patient W in that you:

- b. prescribed testosterone to Patient W:
  - i. which was not clinically-indicated; **Found proved**
  - ii. without first establishing whether the risks of prescribing testosterone were lower than the risks to Patient W's mental and physical health if not prescribed; **Found proved**
  - iii. before entering into a shared care agreement with Dr GY; **Found not proved**
  - iv. without informing Dr GY that you had commenced testosterone treatment; **Found not proved**

843. As to paragraphs 75bi and 75bii, the Tribunal, for reasons indicated in relation to other patients, accepted the evidence of Dr Quinton that in the absence of a confirmed diagnosis of gender dysphoria obtained by means of a series of objective clinical and psychological assessments made over a period of time, accepted there could be no clinical basis for prescribing testosterone, a potentially life changing hormone medication. Moreover, without such evidential basis, it would be impossible to adequately balance the risks of prescribing testosterone against the risks of not doing so.

844. The Tribunal, for the same reasons it gave in relation to paragraph 75ai and 75aiii2 determined that there had been no adequate assessment of Patient W by Dr Webberley to support a diagnosis of gender dysphoria.

845. Accordingly, the Tribunal found paragraph 75bi and ii of the Allegation proved.

846. As to paragraphs 75biii and iv, the Tribunal did not consider that Dr Webberley was under a duty to enter into a shared care agreement with Dr Yu as a pre-requisite to prescribing testosterone to Patient W (assuming that it was

otherwise appropriate to do so). Furthermore, the Tribunal considered that whereas it would always be best practice for a private medical practitioner to inform a patients' GP before prescribing medication (assuming the patient has given consent for this purpose), the Tribunal did not consider that a private medical practitioner is under a duty to do so generally, or in the circumstances of this case.

847. Accordingly, the Tribunal found paragraphs 75biii and iv of the Allegation not proved.

848. In reaching this conclusion, the Tribunal was mindful of GMP which makes provision for the sharing of patient information between medical professionals involved in a patients care. However, it noted that Patient W's GP was made aware of the fact that Patient W was being prescribed testosterone, albeit after prescribing had commenced.

#### Paragraphs 75ci and ii of the Allegation

75. Between June 2018 and September 2018, you failed to provide good medical care to Patient W in that you:
- c. did not record any details as to the prescribing of testosterone to Patient W, including:
    - i. dosage; **Found not proved**
    - ii. date of prescription; **Found not proved**

849. Given that the GenderGP medical records in relation to Patient W before the Tribunal was obviously incomplete, it was unable to conclude, on the balance of probabilities or otherwise, whether Dr Webberley had recorded details of Patient W's testosterone prescription, the dosage or date(s) of prescription.

850. Accordingly, the Tribunal found paragraphs 75ci and ii of the Allegation not proved.

#### Paragraphs 75di and ii of the Allegation

75. Between June 2018 and September 2018, you failed to provide good medical care to Patient W in that you:
- d. did not obtain informed consent from Patient W in that you:
    - i. failed to countersign the consent form; **Found not proved**
    - ii. provided no details as to the verbal consenting process, including whether appropriate communication in dealing with a patient with autism was employed; **Found not proved**

- e. did not provide adequate follow up care. **Found not proved**

851. As to paragraph 75di, the Tribunal had already determined in relation to other patients that Dr Webberley's failure to counter-sign a consent form would not vitiate otherwise informed consent having been given.

852. Accordingly, the Tribunal found paragraphs 75di of the Allegation not proved.

853. With regard to paragraphs 75dii and 75e, the Tribunal had already identified that GenderGP's records in relation to Patient W, and available to the Tribunal, were obviously incomplete. Therefore, the Tribunal was unable to determine what, if anything, did happen in relation to the verbal consenting process, neither was the Tribunal able to determine what, if anything, occurred between Dr Webberley/GenderGP and Patient W with regards to follow up care (although the Tribunal noted that Patient W's father referred to their being more than one skype conversation with Dr Webberley and Patient W). In these circumstances, the Tribunal found paragraphs 75dii and 75e of the Allegation not proved.

#### Paragraphs 76a, b and c of the Allegation

- 76. You provided treatment to Patient W as outlined at paragraph 75 above:
  - a. outside the limits of your expertise as a consultant gastroenterologist; **Found proved**
  - b. without the necessary qualifications and training and experience in transgender medicine; **Found proved**
  - c. whilst failing to adhere to a recognised training pathway in transgender medicine. **Found proved**

854. For the same reasons the Tribunal gave in relation to Patient S and others, the Tribunal found 76a, b and c proved.

#### Patient X

855. Patient X was assigned male at birth and was twenty years old when she first made contact with Gender GP, in May 2018. She had previously consulted her GP, Dr Duckworth, with regards to possible gender dysphoria in November 2017, and her GP had referred her to an NHS gender identity clinic (Nottingham Centre for Transgender Health) in April 2018. However, Patient X was subsequently informed that the waiting list for the GIC was approximately two years long. Therefore, she sought private treatment from Dr Webberley at Gender GP and, in due course, following an 'assessment' process Patient X was prescribed cross-sex hormones.

856. The evidence before the Tribunal in relation to the care received by Patient X from Dr Webberley/Gender GP comprised Patient X's NHS GP records, what

appeared to be complete medical records for Patient X from Gender GP and evidence from Patient X's GP, Dr Duckworth.

#### Paragraph 77a of the Allegation

77. Between August 2018 and June 2019, you failed to provide good clinical care to Patient X in that you:

a. did not establish an adequate MDT; **Found proved**

857. For the same reasons given in relation to other transgender patients the Tribunal had considered, it determined, given that Dr Webberley lacked the qualification, training and/or experience to treat transgender patients autonomously, good clinical care could only have been provided through an adequate MDT.

858. GenderGP's records in respect of Patient X demonstrated that the only professionals involved in Patient X's care, other than Dr Webberley himself, were a Ms Swarbrick and a Ms Olden. The Tribunal noted Dr Duckworth's evidence that initially she had been unsure, as had been Patient X, as to whether Dr HW had been involved in Patient X's care. The Tribunal also observed that there were occasional references to Dr HW within Patient X's Gender GP patient records. However, the Tribunal determined that, even if Dr HW had been involved in Patient X's care in some way, she could not have been regarded as being a member of an adequate MDT because she was at the relevant time subject to suspension by an interim order of the GMC.

859. With regard to the qualification, training and/or experience of Ms Swarbrick, the evidence was unclear. Ms Swarbrick was the only professional at Gender GP to have spoken to Patient X. This was on 31 October 2018, the occasion on which she conducted an 'information-gathering session' with Patient X by telephone. In Ms Swarbrick's report of this session, she signed herself as "*Jackie Swarbrick, MBACP, Dip. Couns.*", "*Counsellor*", although Patient X had at some stage told her GP that she had spoken to a 'psychiatrist' but later said it had been a counsellor she had spoken to.

860. Ms Jane Olden had been referred to in documentation relating to other patients as 'Counsellor, Specialising in Couples, Bereavement and Gender Identity' and also described elsewhere as 'Counsellor and psycho/gender therapist'.

861. Given the uncertainty as to Ms Swarbrick's and Ms Olden's qualifications, training and/or experience, the Tribunal did not consider that there was sufficient evidence, on the balance of probabilities, that they did not have the relevant qualifications, training or experience.

862. For these reasons, the Tribunal was unable to conclude that either Ms Swarbrick or Ms Olden were not qualified mental health professionals meeting the broad criteria identified in WPATH guidelines.

863. Nevertheless, the Tribunal noted that there were no suitably qualified medical gender specialists involved in Patient X's care, it having previously determined that Dr Webberley himself was not suitably qualified in this regard.

864. Further, and in any event, the Tribunal accepted the evidence of Dr Kierans that the management of Patient X's care did not indicate that the practitioners in the GenderGP service were operating as an MDT. The Tribunal determined that Dr Webberley was, essentially, working alone having received information from others from time to time. In the Tribunal's judgement, this fell far short of MDT working, adequate or otherwise.

865. Accordingly, the Tribunal found paragraph 77a of the Allegation proved.

#### Paragraph 77bi of the Allegation

77. Between August 2018 and June 2019, you failed to provide good clinical care to Patient X in that you:

b. diagnosed Patient X with gender dysphoria:

i. without any face-to-face or video consultations with Patient X; **Found proved**

866. As to this paragraph of the Allegation, the Tribunal had already found that Dr Webberley was acting autonomously and not as a member of a multi-disciplinary team. The evidence, in particular GenderGP's medical records in respect of Patient X, demonstrated that Dr Webberley had not ever spoken to Patient X directly, much less had he had any face-to-face or video consultation with his patient. Given that Dr Webberley had responsibility for Patient X's care, in the Tribunal's judgement, it is self-evident that he should have met with his patient either face-to-face or at the very least via video before diagnosing gender dysphoria and proceeding to prescribe cross-sex hormones, potentially life-changing hormone therapy.

867. Accordingly, the Tribunal found paragraph 77bi of the Allegation proved.

#### Paragraphs 77bii1 and 2 of the Allegation

77. Between August 2018 and June 2019, you failed to provide good clinical care to Patient X in that you:

b. diagnosed Patient X with gender dysphoria:

ii. based upon physical and psychological assessments:

1. from unqualified staff; **Found not proved**

2. which you should have recognised were insufficiently detailed; **Found proved**

868. As to paragraphs 77bii1 and 77bii2 of the Allegation, for the reasons given in relation to paragraph 77a, due to the uncertainty as to the qualifications, training and/or experience of Ms Swarbrick and Ms Olden, the Tribunal was unable to conclude that they would not have met the criteria for a mental health professional within the meaning of the WPATH guidelines. As to the allegation that Dr Webberley's diagnosis was based upon a physical assessment from unqualified staff, the Tribunal concluded that there was no physical assessment at all.

869. Therefore, the Tribunal found paragraph 77bii1 of the Allegation not proved.

870. In relation to paragraph 77bii2 of the Allegation, the Tribunal accepted the evidence of Dr Kierans that given the limited information contained on the patient questionnaire completed by Patient X and, particularly, the lack of detailed exploration of relevant matters within Ms Swarbrick's record of her consultation with Patient X. For example, the absence of thorough discussion of Patient X's mental health (despite Patient X having disclosed a history of depression and anxiety), family background and any relevant adverse life experiences, the limited discussion of sexuality and the meaning associated with being seen as gay as an adolescent and also insufficient discussion and/or emphasis on supporting Patient X in accessing fertility counselling and potentially preserving her fertility prior to treatment (the records demonstrate that Patient X had expressed a desire to preserve her fertility).

871. For these reasons, the Tribunal found paragraph 77bii2 of the Allegation proved.

#### Paragraph 77biii of the Allegation

77. Between August 2018 and June 2019, you failed to provide good clinical care to Patient X in that you:

b. diagnosed Patient X with gender dysphoria:

iii. without obtaining an adequate medical history;

**Found proved**

872. The only medical history obtained in relation to Patient X was that recorded within GenderGP's questionnaire, completed by Patient X and Ms Swarbrick's report of her consultation with Patient X. The Tribunal accepted the evidence of Dr Quinton, supported by Dr Kierans, that although some information had been obtained both within the questionnaire and the consultation it did not by any means amount to an adequate medical history. Given that a full medical history should have been obtained prior to a diagnosis of gender dysphoria, the Tribunal found paragraph 77biii proved.

#### Paragraph 77ci, ii, iii1 and 2, and iv of the Allegation

77. Between August 2018 and June 2019, you failed to provide good clinical care to Patient X in that you:

- c. prescribed a 12-week supply of oestradiol patches (100 mcg, twice weekly), micronized progesterone (100 mg, daily) and spironolactone (100 mg daily) to Patient X in March 2019 without:
  - i. any personal contact with Patient X during the course of treatment; **Found proved**
  - ii. obtaining a basic medical history; **Found proved**
  - iii. carrying out a:
    - 1. physical state examination; **Found proved**
    - 2. mental state examination; **Found proved**
  - iv. an adequate discussion with Patient X about the risks and benefits of treatment; **Found proved**

873. In relation to these paragraphs of the Allegation, the Tribunal had already determined that at no time whilst Patient X was Dr Webberley's patient did he meet or speak to Patient X. Accordingly, Dr Webberley could not have done any of those things alleged in paragraphs i to iv, which, on the basis of the expert evidence, the Tribunal accepted he should have done. Further, as to the obtaining of a basic medical history, the Tribunal had already found that which had been obtained by Ms Swarbrick and in the patient questionnaire was insufficiently detailed.

874. Accordingly, the Tribunal found paragraphs 77ci to iv proved.

Paragraph 77cv of the Allegation

77. Between August 2018 and June 2019, you failed to provide good clinical care to Patient X in that you:

- c. prescribed a 12-week supply of oestradiol patches (100 mcg, twice weekly), micronized progesterone (100 mg, daily) and spironolactone (100 mg daily) to Patient X in March 2019 without:
  - v. considering Patient X's baseline investigations beforehand; **Found not proved**

875. As to paragraph 77cv, the Tribunal noted that Dr Webberley requested Patient X's GP to conduct baseline blood tests on 28 January 2019, and the results of those tests were faxed by Dr Duckworth the same day. Dr Quinton opined that there was no evidence from GenderGP's patient records that Dr Webberley had ever personally looked at the baseline test results to assure himself that they were satisfactory. The Tribunal considered that this was an assumption on Dr Quinton's

behalf which was not borne out by the evidence. On the contrary, the medical records contain an entry dated 31 January 2019 making reference to the fact that Dr Webberley had reviewed the blood results and that they were 'all fine'.

876. Accordingly, the Tribunal found paragraph 77cv of the Allegation not proved.

#### Paragraph 77cvi of the Allegation

77. Between August 2018 and June 2019, you failed to provide good clinical care to Patient X in that you:

c. prescribed a 12-week supply of oestradiol patches (100 mcg, twice weekly), micronized progesterone (100 mg, daily) and spironolactone (100 mg daily) to Patient X in March 2019 without:

vi. recording the basis for the prescription;  
**Found not proved**

877. As to paragraph 77cvi, the Tribunal noted that it did not have GenderGP's patient records beyond 15 February 2019. However, the Tribunal did have a copy of the letter written by Dr Webberley to Dr Duckworth on 13 March 2019, produced from her Practice's records, in which Dr Webberley informed her of what appeared to have been the first prescription of MTF cross-sex hormones. Given the gap in GenderGP's records available to the Tribunal, it was unable to conclude that Dr Webberley had not recorded the basis for the prescription in the period from 15 February up to the date on prescription on 13 March 2019.

878. Accordingly, the Tribunal found paragraph 77cvi of the Allegation not proved.

#### Paragraph 77cvii of the Allegation

77. Between August 2018 and June 2019, you failed to provide good clinical care to Patient X in that you:

c. prescribed a 12-week supply of oestradiol patches (100 mcg, twice weekly), micronized progesterone (100 mg, daily) and spironolactone (100 mg daily) to Patient X in March 2019 without:

vii. a plan for holistic review of Patient X's progress apart from blood tests; **Found proved**

879. In relation to paragraph 77cvii the Tribunal accepted the evidence of Dr Quinton and Dr Kierans that following a diagnosis of gender dysphoria and the prescription of cross-sex hormones, the treating clinician(s) should continue to review and monitor the patient's response to treatment, both in respect of the patient's physical health and their psychological wellbeing, and that the clinician(s) should formulate a plan in this regard. The Tribunal noted that Dr Webberley had

made provision and planned for ongoing review by blood tests. However, it was evident from the medical records that there was no consideration or planning beyond this with regard to reviewing the patient's physical or psychological response to treatment.

880. Accordingly, the Tribunal found paragraph 77cvii of the Allegation proved.

Paragraphs 77di, ii and iii1, 2 and 3 of the Allegation

77. Between August 2018 and June 2019, you failed to provide good clinical care to Patient X in that you:

- d. prescribed micronized progesterone:
  - i. contrary to guidance; **Found proved**
  - ii. without evidence of any benefit to Patient X; **Found proved**
  - iii. which increased the risks to Patient X of:
    - 1. impaired breast development; **Found proved**
    - 2. venous thrombo-embolism; **Found proved**
    - 3. breast cancer; **Found proved**

881. Dr Quinton's evidence was that the prescription of micronized progesterone was contrary to guidance, that there was no evidence of any benefit to transgender women within medical literature, and that the medication presented a potential long-term risk from treatment of impaired breast development, venous thrombo-embolism and breast cancer. The Tribunal noted the *'Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline'* which did not recognise micronized progesterone treatment regimen for MTF transgender therapy, but rather detailed regimens containing oestrogen and anti-androgens for the treatment of transgender females. The Tribunal therefore found paragraph 77di of the Allegation proved.

882. Further, the Tribunal accepted Dr Quinton's evidence, with regard to the risks and the lack of benefits of micronized progesterone to transgender women. Therefore, it found paragraphs 77dii and iii proved.

883. Accordingly, the Tribunal found paragraphs 77di, ii and iii1, 2 and 3 of the Allegation proved.

Paragraph 77e of the Allegation

77. Between August 2018 and June 2019, you failed to provide good clinical care to Patient X in that you:

- e. did not keep any records of your care and treatment of Patient X; **Found not proved**

884. Dr Quinton recorded in his report that Dr Webberley had maintained no personal medical records whatsoever in relation to Patient X. In the Tribunal's judgement, having reviewed the medical records, Dr Quinton was mistaken in this regard. Dr Webberley did maintain some medical records relating to Patient X. The Tribunal accepted, as was the evidence of Dr Kierans, that the records were inadequate. However, as this was not the allegation, the Tribunal found it not proved.

885. Accordingly, the Tribunal found paragraph 77e of the Allegation not proved.

Paragraphs 77fi, ii, iii and iv of the Allegation

77. Between August 2018 and June 2019, you failed to provide good clinical care to Patient X in that you:

- f. did not obtain informed consent from Patient X in that you:
  - i. failed to directly contribute to the consenting process with Patient X; **Found not proved**
  - ii. failed to counter-sign the consent documentation; **Found not proved**
  - iii. obtained consent remotely which did not allow Patient X the opportunity to engage with you personally to discuss risks and benefits of treatment; **Found proved**
  - iv. failed to adequately assess Patient X's capacity in light of their mental health concerns. **Found proved**

886. Patient X's GenderGP medical records showed that on 31 January 2019 Patient X was emailed, what Dr Quinton accepted was appropriate and comprehensive information regarding the proposed treatment together with a consent form. This was signed by Patient X on 1 February 2019. Thereafter, on 4 February 2019, Patient X was in email correspondence with non-medical administrative staff at GenderGP, in which Patient X was asked for further information including his understanding of the treatment and its effects and impact that it would have on him and others. There then followed some emails from Patient X providing further information and raising questions which were dealt with by a member of the non-medical administrative staff. The last email in the medical record was dated 14 February 2019 in which a member of GenderGP staff stated, "*a member of the team will be in touch to respond further as soon as possible*". There

was then no further email correspondence in the record or apparent contact with Patient X. As the Tribunal had already observed, the medical record appeared incomplete because Patient X's GP records showed that Dr Webberley did not prescribe cross-sex hormones until 13 March 2019.

887. In these circumstances, the Tribunal was not satisfied, on the balance of probabilities, that there had not been any direct contribution to the consenting process with Patient X by Dr Webberley. Therefore, the Tribunal found paragraph 77fi not proved.

888. The Tribunal had previously determined in relation to other patients, that a failure by Dr Webberley to counter-sign documentation did not prevent, otherwise informed consent, having been given.

889. As to paragraphs 77fiii and iv, the Tribunal noted the evidence of Dr Duckworth, who stated that on 21 February 2019, she had telephoned Patient X as she wished to clarify the assessment that had been made of Patient X by GenderGP. Dr Duckworth recorded this conversation contemporaneously within Patient X's GP record. Dr Duckworth stated that she had been told by Patient X that she had had several emails with the GenderGP clinic, and she had also spoken to a 'psychiatrist' (subsequently referred to by Patient X as a 'counsellor'). Patient X had further stated that they had had to fill out some forms and had been informed by Dr Webberley of the side effects of the medication. There had been no face-to-face assessments, everything had been via email exchange and one telephone conversation with a 'psychiatrist'.

890. On 8 March 2019, Dr Duckworth again spoke to Patient X in a face-to-face consultation. Again, a contemporaneous record of this conversation appeared in the GP record (the accuracy to which was confirmed by Patient X at the time). On this occasion, Patient X again confirmed that there had been no face-to-face assessments with the GenderGP clinic and all communication had been by email. Patient X further told Dr Duckworth that all emails came from Dr Webberley's email address, but the patient was not sure whether it was always him as sometime different people responded from the same email address. Patient X also said that they had had a '30-minute informal chat' with a 'counsellor' (previously referred to by Patient X as a 'psychiatrist'). Patient X went on to describe to Dr Duckworth how she had come to be prescribed cross-sex hormones by Dr Webberley and that the counselling with regard to side effects of the medication had been via leaflets and that they had to sign the consent [form] and return via email.

891. The Tribunal accepted Dr Duckworth's evidence in this regard and what Patient X had told her. Therefore, the Tribunal found paragraph 77fiii and iv proved.

#### Paragraph 78 of the Allegation

78. Your conduct as described at paragraphs 77c – e above was in breach of the interim order of conditions imposed upon your registration during the period of time you treated Patient X. **Found not proved**

892. The only evidence before the Tribunal as to Dr Webberley being subject to an interim order of conditions imposed upon his registration during the time he treated Patient X, was contained in an email sent by Dr Duckworth on 26 February 2019 to the GMC and a passing reference in a complaint made to the GMC by another witness concerning a different patient. In Dr Duckworth's email she referred to having looked at the GMC register that day and that Dr Webberley was shown to have conditions on his registration, one of which prohibited him for prescribing hormone treatment to patients without consultation in person. Beyond this email, the Tribunal had no direct evidence as to when the interim order was made, and/or effective from, or what the full conditions were, or the period over which they were to last. The Tribunal considered the evidence in relation to this allegation unsatisfactory and incomplete and concluded it was not proved.

#### Paragraphs 79a, b and c of the Allegation

79. You provided treatment to Patient X as outlined at paragraph 77 above:
- a. outside the limits of your expertise as a consultant gastroenterologist; **Found proved**
  - b. without the necessary qualifications and training and experience in transgender medicine; **Found proved**
  - c. whilst failing to adhere to a recognised training pathway in transgender medicine. **Found proved**

893. For the same reasons the Tribunal gave in relation to Patient S and others, the Tribunal found 76a, b and c proved.

#### Patient Y

894. Patient Y was assigned female at birth and was 24 years old when he first made contact with GenderGP in October 2018. Patient Y had identified as a man his whole life but had only recently come out as transgender to his friends and family. He had been suffering stress and been to see his GP although he had not told them about being transgender at that point. He had also sought counselling but was, at the time, on a waiting list. Patient Y had also been trying to contact a gender clinic but had received no response. He was concerned about the potentially long waiting time. Hence, Patient Y contacted GenderGP for an initial private appointment so that, he hoped, he could speed up the process of being prescribed testosterone.

#### Paragraph 80a of the Allegation

80. Between 15 October 2018 and 22 March 2019, you failed to provide good clinical care to Patient Y in that you:
- a. did not establish an adequate MDT; **Found proved**

895. For the reasons previously stated in relation to Patient S and other patients, the Tribunal determined that there should have been an MDT involved in the assessment and diagnosis of Patient Y. The evidence contained in the GenderGP records in respect of Patient Y demonstrated that there were five professionals involved in Patient Y's assessment and diagnosis prior to prescription of testosterone; Dr Webberley, Ms Marianne Oakes, Ms Claire Booth, Ms Jayne Olden and Ms Sally Coles (RGN). Ms Oakes, Ms Booth and Ms Olden were counsellors and, in respect of whom, the Tribunal was unclear as to their qualifications, training and/or experience in the assessment and diagnosis of gender dysphoria. Ms Sally Coles was a Specialist Paediatric Nurse (and an independent nurse prescriber), again the Tribunal was unable to determine whether she had any qualification, training or experience in transgender medicine. In any event, the Tribunal concluded that, even if one or other of the counsellors could be regarded as mental health professional within the meaning of the WPATH guidelines, there was no endocrinologist/gender specialist which would have been necessary for an adequate MDT.

896. Furthermore, the Tribunal determined, by reference to Patient Y's GenderGP records, that there was no evidence of proper discussions, joint decision making, or joint care planning as would be required for an adequate functioning MDT.

897. The Tribunal had noted that the records contained a draft letter dated 21 December 2018 from GenderGP to Patient Y's GP referring to 'rigorous' assessments having been undertaken:

*"including psychological and medical evaluation and further information gathering sessions with our team of highly experienced psychologists and counsellors".*

898. Despite this assertion, there was no evidence within the medical record that this statement reflected the reality.

899. Accordingly, the Tribunal found paragraph 80a of the Allegation proved.

Paragraphs 80bi, ii, iii1 and 2, and iv of the Allegation

80. Between 15 October 2018 and 22 March 2019, you failed to provide good clinical care to Patient Y in that you:

b. diagnosed Patient Y as suffering from gender dysphoria based solely upon:

i. Patient Y's answers to Gender GP questionnaires without further investigation; **Found not proved**

ii. the content of Patient Y's emails in exchanges with Gender GP staff who lacked the necessary qualifications in mental or physical healthcare; **Found not proved**

- iii. a report by a counsellor who:
  - 1. lacked adequate qualifications to reach a clinical diagnosis of gender dysphoria; **Found not proved**
  - 2. only engaged with Patient Y in a single 20-minute video consultation; **Found not proved**
- iv. a 30-minute consultation with Patient Y by a registered nurse who failed to keep a formal record of that consultation; **Found not proved**

900. The premise of this allegation was that Dr Webberley’s diagnosis of gender dysphoria was based solely upon those matters set out in paragraphs 80bi-iv. In relation to this allegation, the GMC relied upon Dr Quinton’s opinion which was derived from his analysis of the patient records.

901. The Tribunal observed however that Dr Quinton, in giving his conclusions in relation to this aspect of the case, had apparently not taken into account the fact that there was a relatively detailed report from Ms Jayne Olden detailing an ‘information gathering session’ (either by phone or by skype) for approximately 45 minutes. The Tribunal therefore concluded that paragraph 80b was not proved as this document suggested that Dr Webberley had not made his diagnosis ‘solely’ upon the matters alleged in paragraphs 80bi-iv.

902. The Tribunal hesitated before reaching this conclusion because it was mindful of the fact that Dr Kierans had criticised Ms Olden’s the report as it was, in her opinion, inadequate for the purposes of a psychological assessment. The Tribunal also considered whether it should, of its own motion, amend the allegation after inviting submissions. However, given the stage of the proceedings that had been reached, and Dr Webberley was neither present nor represented, and the fact that Dr Quinton may have reached a conclusion based upon a false premise, the Tribunal did not consider it appropriate or fair to consider amendment at this late stage, given that Dr Webberley was neither present, nor represented. Therefore, an amendment could not be made without the risk of injustice.

903. Accordingly, the Tribunal found paragraphs 80bi, ii, iii1 and 2, and iv of the Allegation not proved.

#### Paragraphs 80ci, ii and iii of the Allegation

- 80. Between 15 October 2018 and 22 March 2019, you failed to provide good clinical care to Patient Y in that you:
  - c. did not conduct any examination yourself, including that you did not:

- i. elicit a face-to-face medical history; **Found proved**
- ii. conduct a mental state examination; **Found proved**
- iii. obtain basic clinical observations; **Found proved**

904. The Tribunal determined that, in the absence of an adequate functioning MDT, Dr Webberley, as the treating clinician responsible for the care of Patient Y, should have at the very least, elicited an adequate medical history, conducted a basic mental state examination and obtained basic clinical observations himself. The GenderGP medical records showed that not only did Dr Webberley fail to do any of these things, he had never met Patient Y either face-to-face or remotely, neither had he ever spoken to him.

905. Accordingly, the Tribunal found paragraphs 80ci, ii and iii of the Allegation proved.

Paragraphs 80di and ii1, 2, 3 and 4 of the Allegation

80. Between 15 October 2018 and 22 March 2019, you failed to provide good clinical care to Patient Y in that you:

- d. allowed Patient Y to be prescribed cross-hormone testosterone treatment:
  - i. by individuals who were not recognised specialists in transgender medicine; **Found proved**
  - ii. without any personal consultation with Patient Y in order to:
    1. elicit a basic medical history; **Found proved**
    2. conduct a physical state examination; **Found proved**
    3. conduct a mental state examination; **Found proved**
    4. discuss risks and benefits of proposed treatment; **Found proved**

906. In the light of the Tribunal decision in relation to paragraph 80c, the Tribunal concluded that, as the treating clinician responsible for Patient Y's care, he should not have allowed Patient Y to have been prescribed cross-sex hormones by others who were not recognised specialists in transgender medicine.

907. The GenderGP patient records show that Patient Y had, in the relevant period, been prescribed testosterone by two others. Ms Sally Coles, described by Dr

Webberley in a summary note to the GMC as RGN, Specialist Paediatric Nurse, and on a prescription that she issued as an 'independent prescribing nurse practitioner'. The other prescriber was Dr Roxana Mateescu, based in Hungary, described during an Interim Orders Tribunal hearing as a geriatrician specialising in rehabilitation following illness and injury.

908. Accordingly, the Tribunal found paragraphs 80di of the Allegation proved.

909. In relation to paragraphs 80dii1, 2, 3 and 4, the Tribunal determined that Dr Webberley in his capacity as the treating clinician should have had a personal consultation with Patient Y for the purposes alleged and as previously observed, Dr Webberley had not ever spoken to this patient.

910. Accordingly, the Tribunal found paragraphs 80dii1, 2, 3 and 4 of the Allegation proved.

#### Paragraph 80e of the Allegation

80. Between 15 October 2018 and 22 March 2019, you failed to provide good clinical care to Patient Y in that you:

- e. did not advise Patient Y or any of Patient Y's GPs during the period of treatment through Gender GP that you were not directly prescribing to Patient Y; **Found proved**

911. The Tribunal concluded from the GenderGP medical records in respect of Patient Y, that Dr Webberley had held himself out to Patient Y and his GP as being the prescribing doctor. In particular, the Tribunal had regard to letters sent to Patient Y's GP of 19 February 2019 and 27 March 2019 in which he identified himself as the prescribing doctor ("*I am writing to confirm the up-to-date treatment I have prescribed*"). In these circumstances, the Tribunal concluded that he should have advised both Patient Y and Patient Y's GPs that he would not be directly prescribing which the evidence demonstrated he had not done.

912. Accordingly, the Tribunal found paragraph 80e of the Allegation proved.

#### Paragraphs 80fi, ii and iii of the Allegation

80. Between 15 October 2018 and 22 March 2019, you failed to provide good clinical care to Patient Y in that you:

- f. did not plan to review Patient Y throughout the period of treatment in order to periodically assess their:
  - i. physical wellbeing; **Found proved**
  - ii. mental wellbeing; **Found proved**

- iii. feelings towards anticipated changes resulting from hormone therapy; **Found proved**

913. The Tribunal accepted the evidence of Dr Quinton and Dr Kierans respectively that, after commencing cross sex hormone treatment, there should have been a treatment plan to review Patient Y's physical wellbeing and response to treatment, and also his mental wellbeing and response to treatment, which would have included Patient Y's feeling towards the changes to be anticipated from the hormone therapy. The Tribunal accepted, on the evidence of both experts, that the process of assessment and review did not end upon the commencement of cross-sex hormone treatment. Rather, there should have been a continuing process of review.

914. Accordingly, the Tribunal found paragraphs 80fi, ii and iii of the Allegation proved.

#### Paragraphs 80gi and ii of the Allegation

80. Between 15 October 2018 and 22 March 2019, you failed to provide good clinical care to Patient Y in that you:

- g. did not adjust the testosterone prescriptions for Patient Y when blood results showed that Patient Y had:
  - i. nearly twice the upper limit of testosterone in the normal male reference range; **Found proved**
  - ii. developed abnormalities in their red blood cell morphology; **Found proved**

915. The Tribunal accepted the evidence of Dr Quinton that for Patient Y (who had reported his own height as being 5 foot 3 inches) the dose of testosterone was too high. This resulted in serum testosterone concentrations being nearly twice the upper limit of the normal male reference range as was apparent from blood tests performed on 4 March 2019. These blood tests also showed that Patient Y had developed abnormalities in his red blood cell morphology. In the light of these results, Dr Quinton's evidence was that the testosterone dose should have been reduced. The dose was not reduced, and Dr Webberley caused a repeat prescription to be issued on 19 March 2019 by Dr Mateescu.

916. Accordingly, the Tribunal found paragraphs 80gi and ii of the Allegation proved.

#### Paragraphs 80hi and ii of the Allegation

80. Between 15 October 2018 and 22 March 2019, you failed to provide good clinical care to Patient Y in that you:

- h. did not establish a treatment plan for Patient Y, including:

- i. arrangements for face-to-face reviews every three to four months; **Found proved**
- ii. target ranges to be achieved for blood test results; **Found proved**

917. For the same reasons given in relation to paragraph 80f, the Tribunal found paragraphs 80hi and ii of the Allegation proved.

Paragraph 80i of the Allegation

80. Between 15 October 2018 and 22 March 2019, you failed to provide good clinical care to Patient Y in that you:

- i. did not liaise with Patient Y's mental health workers; **Found not proved**

918. The GP records and GenderGP records in respect of Patient Y did not show that Patient Y had been significantly involved with 'mental health workers'. There were references to stress, potentially related to his gender identity, and when Patient Y first approached GenderGP, he referred to being on a waiting list for counselling. In the subsequent questionnaire Patient Y indicated that he had spoken to a counsellor on the phone but remained on a waiting list for counselling. Finally, within Patient Y's GP records a letter dated 13 February 2019 indicated that Patient Y had attended two appointments for counselling following a self-referral, the most recent of which had been on 20 December 2018. There was nothing in GenderGP records to indicate that they, or Dr Webberley, had been made aware of these appointments. In these circumstances, the Tribunal did not consider that even if it could be said that Patient Y was involved with 'mental health workers', Dr Webberley could not be criticised for having failed to have liaised with them.

919. Accordingly, the Tribunal found paragraphs 80i of the Allegation not proved.

Paragraphs 80ji and ii of the Allegation

80. Between 15 October 2018 and 22 March 2019, you failed to provide good clinical care to Patient Y in that you:

- j. did not personally participate in the process of obtaining consent from Patient Y in that you failed to:
  - i. contemporaneously counter-sign Patient Y's consent to treatment form; **Found not proved**
  - ii. give Patient Y the opportunity to discuss risks and benefits of the proposed treatment with you; **Found proved**

920. As to 80ji, for the same reasons given in respect of other patients where a failure to counter-sign a consent form by Dr Webberley has been alleged, the Tribunal found paragraph 80ji of the Allegation not proved.

921. However, the Tribunal had already found that Dr Webberley had never either met or spoken to his patient, indeed, apart from a single email sent on behalf of Dr Webberley, he did not communicate with Patient Y ever. Therefore, the Tribunal concluded that Patient Y did not have, nor was he given, the opportunity to discuss the risks and benefits of the proposed treatment.

922. In reaching this conclusion, the Tribunal noted that there had been an email sent by an administrative member of staff, on 28 November 2018, inviting any questions or queries by the patient:

*“before we go ahead and in order to help Dr Webberley undertake a final review of your case and make a final decision regarding treatment...”*

923. The Tribunal considered this fell far short of Dr Webberley personally participating in the process of obtaining consent and giving Patient Y adequate opportunity to discuss risks and benefits of the proposed treatment.

924. Accordingly, the Tribunal found paragraph 80jii of the Allegation proved.

#### Paragraph 80k of the Allegation

80. Between 15 October 2018 and 22 March 2019, you failed to provide good clinical care to Patient Y in that you:

- k. did not maintain you own medical records for Patent Y.  
**Found not proved**

925. There was a patient record held by GenderGP in relation to Patient Y. The documentation therein was almost exclusively generated by other members of staff and not by Dr Webberley. However, there was some limited information recorded in respect of which Dr Webberley was the source, including letters to the GP concerning what he had done in respect of prescribing. The Tribunal would have found proved an allegation that Dr Webberley’s records in respect of patient Y were wholly inadequate. However, the Tribunal did not consider that the allegation that Dr Webberley had not maintained his own medical record for Patient Y could be proved.

926. The Tribunal considered there was the potential for injustice if it were to amend the Allegation of its own volition at this stage and where Dr Webberley was neither present nor represented.

927. Accordingly, the Tribunal found paragraph 80k of the Allegation not proved.

#### Paragraphs 81a, b and c of the Allegation

81. You provided treatment to Patient Y as outlined at paragraph 80 above:
- a. outside the limits of your expertise as a consultant gastroenterologist; **Found proved**
  - b. without the necessary qualifications and training and experience in transgender medicine; **Found proved**
  - c. whilst failing to adhere to a recognised training pathway in transgender medicine. **Found proved**

928. For the same reasons the Tribunal gave at paragraph 65 of the Allegation in relation to Patient S, and in relation to other patients, the Tribunal found paragraphs 81a, b and c of the Allegation proved.

#### Paragraph 82 of the Allegation

82. Your actions as described at one or more of paragraphs 64 - 81 were outwith UK guidance in that they were contrary to the NHS Standard Contract for Gender Identity Development Service for Children and Adolescents issued in 2016. **Found not proved**

929. The Tribunal considered that paragraph 82 of the Allegation was based upon a false premise, that premise being that 'UK guidance' in relation to the care of transgender patients is reflected within the NHS Standard Contract for Gender Identity Development Service for Children and Adolescents (2016) ('The NHS Contract'). In the Tribunal's judgement, The NHS Contract was no more than a service specification for the provision of GIDS services for children and adolescents provided through the NHS.

930. The Tribunal acknowledged that the provisions of the NHS service contract reflected recognised best practice within the NHS, and in many respects, echoed guidance contained in WPATH and elsewhere. However, the Tribunal did not consider that Dr Webberley/GenderGP, as a private health provider, had an obligation or duty to conform to these service specifications within the NHS service contract.

931. In reaching this conclusion, the Tribunal did not find that Dr Webberley had acted within the specification of the NHS service contract, simply, he was under no obligation to do so.

932. Accordingly, the Tribunal found paragraph 82 of the Allegation not proved.

#### In Summary

933. The Tribunal, in its determination of the allegation as set out above, had considered the evidence in relation to each separate allegation, and each individual patient, separately. The Tribunal were conscious of the fact that in proceedings

alleging misconduct against a doctor in which a number of similar allegations are made in respect of different patients, evidence in relation to one patient can, on occasions, be admissible in relation to the issues to be determined, concerning another under established principles of cross admissibility.

934. In this case, the Tribunal did not consider that it was either appropriate or necessary to consider cross admissibility. In relation to those matters the Tribunal found proved, it was able to be satisfied, on the balance of probabilities, upon the evidence relevant to the patient concerned alone. On the matters the Tribunal found not proved, it did not consider that the evidence in relation to any of the other patients assisted the Tribunal one way or the other.

935. This is not to say that the reasons for the findings made in respect of identical allegations made against different patients were not, on a number of occasions, the same.

936. However, the Tribunal at the conclusion of its deliberations, and having reviewed those allegations it had found proved in relation to each of the patients, considered that there was a common theme apparent in relation to all of the BMH and GenderGP patients cared for by Dr Webberley.

- a. All patients had contacted BMH/GenderGP with a view as to the type of hormone treatment they required.
- b. All patients, whether BMH / GenderGP patients, underwent what the Tribunal considered to be an essentially formulaic or 'tick box' online process whereby, before any diagnosis, the patient would be emailed with printed information leaflets, draft agreements for treatment and/or consent forms for treatment.
- c. In the case of the androgen patients, blood tests would be provided which did not support a diagnosis of hypogonadism. In the case of transgender patients, superficial and inadequate assessments would be undertaken with a counsellor. These were described as 'information gathering sessions' and would be limited to usually a single telephone/skype consultation during which time the patient would confirm their desire to transition.
- d. The patient's interactions with BMH or Gender GP prior to diagnosis and prescription would be mainly with non-medical staff via email. There would be very limited direct communication as between Dr Webberley or his patients. On a number of occasions, he would not have ever spoken to his patient.
- e. With regard to both the BMH and GenderGP patients there would be an absence of enquiry or exploration by Dr Webberley with the patient to establish whether there was a clinical need for the treatment which the patient sought. Neither would there be any attempt to obtain corroboration of the patient's narrative or to

obtain a complete medical background by liaison with the patient's GP or other medical professionals who were known to have been involved in the patient's previous medical care.

- f. At the conclusion of the process, in every case the patient was prescribed the treatment which they had sought at the outset. On no occasion had Dr Webberley disagreed with the diagnosis sought or failed to prescribe the treatment sought, neither did he seek to discuss or offer alternatives to treatment. The Tribunal noted that a recurring phrase within many of the patient records was that *"there is no reason not to prescribe"* or *"I see no reason not to prescribe"* or similar. In the context of the evidence as a whole, the Tribunal considered that this was a telling phrase. In the Tribunal's view it was illustrative of an apparent intention to prescribe according to a patient's wishes and not because Dr Webberley had, following an adequate critical and objective assessment, made a diagnosis and concluded that the treatment was clinically indicated.

937. The Tribunal did not consider that the similarities it had identified following its determinations, in relation to the numerous patients under the care of Dr Webberley, could be adequately explained by coincidence.

938. Therefore, the Tribunal did not consider that the inadequate care provided to the patients could be regarded as isolated incidents. Rather, they represented a pattern of substandard care. Further, the Tribunal considered that this underlined the conclusion that the Tribunal had already reached that Dr Webberley did not have either the qualification, training or experience to treat either the androgen BMH patients or his GenderGP transgender patients.

939. Finally, in relation to Dr Webberley's transgender patients, the Tribunal acknowledged and recognised that they all may have been in need of assessment and treatment for their gender dysphoria, either by way of puberty blockers in relation to the child/adolescent patients, or cross-sex hormones in the case of the adult patients seeking gender affirmation treatment. Further, these patients frequently considered, in the Tribunal's judgement, and for good reason, that they had been let down by the systems in place and the resources available for the provision of puberty blocking and gender affirming treatment within the NHS. All of the transgender patients with which the Tribunal was concerned had sought to access NHS care, but due to the inherent delays therein, they had sought treatment in the private sector through GenderGP.

## **Gender GP**

### Paragraphs 83 and 84 of the Allegation

83. Until 2019, alongside Dr HW, you operated and controlled the company known as Gender GP, through which you provided care and treatment as stated at paragraphs 64 – 82 above. **Found proved**

84. In 2019, on the governance page of the Gender GP website it stated that ‘all medical advice and prescriptions are provided by doctors working outside of the UK’. **Found proved**

940. The Tribunal determined from the documentation before it, which included ‘Shared Care Agreements’ between GenderGP and various GPs, that GenderGP was a trading name of ‘Online GP Services Limited’ and that this was a company operated and controlled by Dr Helen Webberley (Dr HW) and Dr Webberley. Further, Companies House documentation from May 2019 showed that Dr HW was a director of Online GP Services Limited (appointed 18 November 2014) as was Dr Webberley (appointed 20 January 2017) and, patient records demonstrated that this was a company through which care and treatment had been provided by Dr Webberley in respect of Patients S-Y. The Tribunal therefore found paragraph 83 of the Allegation proved.

941. In relation to paragraph 84, the Tribunal was referred to the governance page of the GenderGP website, as at 2019, and therefore found this paragraph of the Allegation proved.

#### Paragraphs 85a and b of the Allegation

85. The operating method of Gender GP as described at paragraph 84 above was motivated by efforts to avoid the regulatory framework of the United Kingdom, including regulation by the:

- a. CQC; **Found proved**
- b. HIW. **Found proved**

942. On 16 May 2019 an article was published by GenderGP on the GenderGP website. The article concerned regulatory action being taken at that time by the GMC in relation to Dr Webberley and Dr HW. The article made reference to Dr Webberley being the fourth doctor to be restricted from treating gender variant patients. It stated that this restriction upon a ‘highly experienced doctor’ would leave 1600 patients at risk of sudden withdrawal of treatment and that GenderGP had ‘taken the necessary step of moving its working hub outside of the UK’. The article went on to state:

*“In response, to secure continuity of care for these patients, GenderGP has taken the necessary step of moving its working hub and medical provision outside of the UK. Patients will experience no change in service other than the reassurance that their care will no longer be subject to what Dr [HW] and Mike Webberley have referred to as the “institutional transphobia” that has been evidence since Dr [HW] first came under investigation in 2016.*

*Having seen the restrictions placed on two previous doctors who have provided gender-affirming care in the UK, and then seeing the action taken against Dr [HW], and now Dr Mike Webberley, it is apparent that any doctor*

*working in this field in the UK will be subject to the same level of discrimination.*

*As such, provision has been made to take the medical care and management of all GenderGP services outside of the UK. This will ensure that all current and future trans people who depend on their services will have no break in the care they need.”*

943. In the period leading up to the publication of this article, the corporate structure and mode of operation of ‘GenderGP’ was changed. A screen shot of the GenderGP website in 2019 showed that GenderGP was owned by Spectrum Support Services Ltd (‘Spectrum’) a company with a registered office in Belize and which had become the registered office of GenderGP.

944. The ongoing link between Dr Webberley and GenderGP, after this change, was evident from the fact that, in September 2019, Spectrum had a sole director registered at Companies House; that director was another company, Asaar Technology Limited (‘Asaar’), which had been registered as the sole director of Spectrum since 17 April 2019.

945. UK Companies House entries for Asaar showed that its registered office was Dr Webberley’s home address in Abergavenny, Wales and Dr Webberley was registered as a director of Asaar, and Dr HW was registered as a person with significant control, both with effect from 17 April 2019.

946. Asaar was formerly registered at the same London address as Online GP Services Ltd, which was the previous company trading as GenderGP and the company that Dr Webberley was a registered director of, until April 2019.

947. The Tribunal determined that the change in operating method, by removing GenderGP from incorporation in the UK, so that it became registered in Belize, was motivated by those who had operational control of the company, and which included Dr Webberley, to avoid the regulatory framework of the United Kingdom and which would have necessarily included the Care Quality Commission (‘CQC’) and Health Improvement Wales (‘HIW’), as the content of GenderGP’s article of 16 May 2019 made explicitly clear.

948. Accordingly, the Tribunal found paragraphs 85a and b of the Allegation proved.

Paragraphs 86a and b, 87a and b, 88 and 89 of the Allegation

86. In November 2018:

- a. the only General Practitioner at Gender GP, Dr HW, was subject to an interim order of suspension (‘the IOT Order’);  
**Found proved**

- b. there were no other GPs practising as part of Gender GP.  
**Found proved**

87. You knew that following the IOT Order:

- a. Dr HW was unable to participate in the work of Gender GP in her capacity as General Practitioner; **Found proved**
- b. there were no other GPs practising as part of Gender GP.  
**Found proved**

88. Following the IOT Order you retained the name of your company as Gender GP. **Found proved**

89. Your conduct as outlined at paragraph 88 above was dishonest by reason paragraphs 86 and 87. **Found not proved**

949. There was no direct evidence as to the Interim Order of Suspension made in respect of Dr HW, or the precise period over which the order was in place. Neither was there direct evidence that no other GPs were practising as part of GenderGP at the relevant time, or that Dr Webberley knew of these facts. The GMC relied on witness evidence and documents from which it was submitted these facts could be inferred.

950. By reference to this indirect evidence, the Tribunal inferred, on the balance of probabilities, that the facts alleged at paragraphs 86 and 87 were true. Therefore, the Tribunal found these paragraphs proved. However, the Tribunal did not consider that Dr Webberley's conduct in the light of these facts could be regarded as dishonest. The reason being that the Tribunal determined that, absent an explicit representation that there were GPs practising as part of GenderGP, the retention of the trading name 'GenderGP', a name that had been in use for some considerable time, would not be regarded as dishonest by the standards of ordinary decent people. It followed, from the Tribunal's reasoning, that the continued use of this trading name would not necessarily indicate to ordinary decent people that there were GPs practising from the business.

951. Accordingly, the Tribunal found paragraphs 86a and b, 87a and b, and 88 of the Allegation proved and paragraph 89 not proved.

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

952. The Tribunal has determined the facts as follows:

#### Patient A

1. Between 12 April 2017 and on or around 3 August 2018, you failed to provide good clinical care to Patient A in that you:
  - a. did not hold a consultation with Patient A; **Found proved**

- b. did not elicit an adequate medical history from Patient A, in that you did not elicit details of:
    - i. sexual symptoms; **Found proved**
    - ii. non-sexual symptoms; **Found proved**
    - iii. answers to general health questions concerning the presenting complaint; **Found proved**
  - c. did not perform any physical or mental health examination; **Found not proved**
  - d. inappropriately diagnosed Patient A with hypogonadism in that:
    - i. the diagnosis was not supported by laboratory results; **Found proved**
    - ii. you failed to consider any alternative diagnosis; **Found proved**
  - e. prescribed testosterone, Human Chorionic Gonadotropin ('hCG') and anastrozole which was:
    - i. not clinically indicated; **Found proved**
    - ii. unsafe; **Found proved**
    - iii. not recognised as therapeutic practice in medicine; **Found proved**
  - f. did not conduct tests adequately; **Found not proved**
  - g. inappropriately relied on non-medically trained members of staff to review results of Patient A's blood tests; **Found not proved**
  - h. did not communicate at all with Patient A during the course of his treatment; **Found not proved**
  - i. did not provide adequate follow up care in that you failed to arrange a follow-up consultation with Patient A after treatment had commenced; **Found proved**
  - j. did not respond to follow-up blood tests which indicated over-treatment **Found proved**
2. The Participation Agreement & Informed Consent Form and the Consent for Testosterone Replacement Therapy Form ('the Consent Forms') provided to Patient A stated that:
- a. the higher limit of normal testosterone range was 40 nmol/L; **Found proved**

- b. untreated hypogonadism can increase the risk of:
    - i. heart disease; **Found proved**
    - ii. Alzheimer's disease; **Found proved**
    - iii. premature death; **Found proved**
  - c. the treatment provided was 'TRT' (testosterone replacement therapy). **Found proved**
3. You knew that the information in the Consent Form was untrue as:
- a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **Found proved**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **Found not proved**
    - ii. Alzheimer's disease; **Found not proved**
    - iii. premature death; **Found not proved**
  - c. the treatment to be provided would increase testosterone above normal limits and was not TRT. **Found not proved**
4. Your conduct as set out at paragraph 2 was dishonest by reason of paragraph 3. **Found proved (in relation to 2a by reason of 3a)**
5. You did not obtain informed consent from Patient A for treatment you provided in that:
- a. you failed to counter-sign the Consent Forms; **Found not proved**
  - b. the Consent Forms contained statements which were untrue. **Found proved**

#### Patient B

6. Between ~~15 June 2017~~ 22 March 2017 and 17 September 2018, you failed to provide good clinical care to Patient B in that you:
- a. did not hold a consultation with Patient B; **Found proved**
  - b. did not yourself elicit an adequate medical history from Patient HO, in that you did not elicit details of:
    - i. sexual symptoms; **Found proved**
    - ii. non-sexual symptoms; **Found proved**

- iii. answers to general health questions concerning the presenting complaint; **Found proved**
    - iv. details of his treatment for high blood pressure with doxazosin; **Found not proved**
  - c. did not perform any physical or mental health examination of Patient B; **Found not proved**
  - d. inappropriately diagnosed Patient B with hypogonadism in that:
    - i. the diagnosis was not supported by laboratory results; **Found proved**
    - ii. you failed to consider any alternative diagnosis; **Found proved**
  - e. prescribed testosterone which was:
    - i. not clinically indicated; **Found proved**
    - ii. unsafe; **Found proved**
  - f. did not conduct tests adequately; **Found not proved**
  - g. did not review Patient B's:
    - i. laboratory test results; **Found not proved**
    - ii. medication; **Found not proved**
  - h. inappropriately relied on a non-medically trained member of staff to review Patient B's laboratory results; **Found not proved**
  - i. did not adequately communicate with Patient B in that you:
    - i. delegated communications to non-medically trained members of staff when it was inappropriate to do so; **Found not proved**
    - ii. failed to maintain regular correspondence; **Found not proved**
  - j. did not provide adequate follow up care in that you relied entirely upon email communication between Patient B and non-clinical facilitators. **Found not proved**
- 7. The Consent Forms provided to Patient B stated that:
  - a. the higher limit of normal testosterone range was 40 nmol/L; **Found not proved**
  - b. untreated hypogonadism can increase the risk of:
    - i. heart disease; **Found proved**

- ii. Alzheimer's disease; **Found proved**
    - iii. premature death; **Found proved**
  - c. the treatment provided was TRT. **Found proved**
8. You knew that the information in the Consent Forms was untrue as:
- a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **Found proved**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **Found not proved**
    - ii. Alzheimer's disease; **Found not proved**
    - iii. premature death; **Found not proved**
  - c. the treatment to be provided would increase testosterone above normal limits and was not TRT. **Found not proved**
9. Your conduct as set out at paragraph 7 was dishonest by reason of paragraph 8. **Found proved (in relation to 7a by reason of 8a)**
10. You did not obtain informed consent from Patient B for treatment you provided in that:
- a. you failed to counter-sign the Consent Forms; **Found not proved**
  - b. the Consent Forms contained statements which were untrue. **Found proved**

Patient C

11. Between 26 July 2017 and 29 June 2018, you failed to provide good clinical care to Patient C in that you:
- a. consulted with Patient C on 17 August 2017 and failed to:
    - i. elicit an adequate medical history in that you:
      - 1. relied upon details obtained by a non-medically trained member of staff; **Found not proved**
      - 2. failed to elicit details of sexual symptoms; **Found not proved**
      - 3. failed to elicit details of non-sexual symptoms; **Found not proved**

4. failed to ask general health questions concerning the presenting complaint; **Found not proved**
  - b. did not perform any physical or mental health examination; **Found not proved**
  - c. inappropriately diagnosed Patient C with hypogonadism requiring long term treatment in that:
    - i. the diagnosis was not supported by laboratory results; **Found proved**
    - ii. you failed to consider any alternative diagnosis; **Found proved**
  - d. prescribed testosterone, hCG and anastrozole which was:
    - i. not clinically indicated; **Found proved**
    - ii. unsafe; **Found proved**
    - iii. not recognised as therapeutic practice in medicine; **Found proved**
  - e. did not conduct tests adequately; **Found proved**
  - f. did not review any test results performed during the course of Patient C's treatment; **Found not proved**
  - g. did not adequately communicate with Patient C; **Found not proved**
  - h. did not provide adequate follow up care in that you failed to arrange a follow-up consultation with Patient C after treatment had commenced. **Found not proved**
12. The Consent Forms provided to Patient C stated that:
  - a. the higher limit of normal testosterone range was 40 nmol/L; **Found proved**
  - b. untreated hypogonadism can increase risk of:
    - i. heart disease; **Found proved**
    - ii. Alzheimer's disease; **Found proved**
    - iii. premature death; **Found proved**
  - c. the treatment provided was TRT. **Found proved**
13. You knew that the information in the Consent Forms was untrue as:

- a. 40 nmol/L exceeded laboratory normal ranges for testosterone;  
**Found proved**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **Found not proved**
    - ii. Alzheimer's disease; **Found not proved**
    - iii. Premature death; **Found not proved**
  - c. the treatment provided increased testosterone above normal limits and was not TRT. **Found not proved**
14. Your conduct as set out at paragraph 12 was dishonest by reason of paragraph 13. **Found proved (in relation to 12a by reason of 13a)**
15. You did not obtain informed consent from Patient C for treatment you provided in that:
- a. you failed to counter-sign the Consent Forms; **Found not proved**
  - b. the Consent Forms contained statements which were untrue.  
**Found proved**

Patient D

16. Between September 2017 and September 2018, you failed to provide good clinical care to Patient D in that you:
- a. did not hold a consultation with Patient D; **Found proved**
  - b. did not elicit an adequate medical history from Patient D, in that you did not elicit details of:
    - i. sexual symptoms; **Found proved**
    - ii. non-sexual symptoms; **Found proved**
    - iii. answers to general health questions concerning the complaint; **Found proved**
  - c. did not perform any physical or mental health examination;  
**Found not proved**
  - d. inappropriately diagnosed Patient D with hypogonadism in that:
    - i. the diagnosis was not supported by laboratory results;  
**Found proved**
    - ii. you failed to consider any alternative diagnosis;  
**Found proved**

- e. prescribed testosterone, hCG, anastrozole and mesterolone which was:
  - i. not clinically indicated; **Found proved**
  - ii. unsafe; **Found proved**
- f. did not conduct tests adequately in that you failed to:
  - i. specify the conditions under which blood should be drawn; **Found not proved**
  - ii. check Patient D's full blood count for haematocrit until five months after starting treatment; **Found proved**
- g. did not accurately interpret test results on 4 September 2017 when they showed evidence of:
  - i. anabolic steroid abuse; **Found not proved**
  - ii. clinically significant pituitary mass lesion; **Found not proved**
  - iii. acute kidney injury; **Found not proved**
  - iv. intake of undeclared creatine supplements; **Found not proved**
- h. did not accurately interpret repeat test results on 15 February 2018 when they showed evidence of that as set out at paragraph 16.g above; **Found not proved**
- i. did not reduce Patient D's medication following receipt of test results as set out at paragraphs 16.g – h above; **Found not proved**
- j. did not adequately communicate with Patient D in that you delegated communications to non-medically trained members of staff when it was inappropriate to do so; **Found not proved**
- k. did not provide adequate follow up care in that you:
  - i. failed to arrange a follow-up consultation with Patient D after treatment had commenced; **Found not proved**
  - ii. relied upon email communication between Patient D and non-clinical facilitators. **Found not proved**

17. The Consent Forms provided to Patient D stated that:

- a. the higher limit of normal testosterone range was 40 nmol/L; **Found proved**
- b. untreated hypogonadism can increase risk of:
  - i. heart disease; **Found proved**

- ii. Alzheimer's disease; **Found proved**
  - iii. premature death; **Found proved**
  - c. the treatment provided was TRT; **Found proved**
  - d. Patient D will not take 'any type of anabolic steroid'.  
**Found proved**
18. You knew that the information in the Consent Forms was untrue as:
- a. 40 nmol/L exceeded laboratory normal ranges for testosterone;  
**Found proved**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **Found not proved**
    - ii. Alzheimer's disease; **Found not proved**
    - iii. premature death; **Found not proved**
  - c. the treatment provided increased testosterone above normal limits and was not TRT **Found not proved**
  - d. you prescribed or arranged to be prescribed anabolic steroids to Patient D. **Found not proved**
19. Your conduct as set out at paragraph 17 was dishonest by reason of paragraph 18. **Found proved (in relation to 17a by reason of 18a)**
20. You did not obtain informed consent from Patient D for treatment you provided in that:
- a. you failed to counter-sign the Consent Forms; **Found not proved**
  - b. the Consent Forms contained statements which were untrue.  
**Found proved**

#### Patient E

21. Between September 2017 and September 2018, you failed to provide good clinical care to Patient E in that you:
- a. did not hold a consultation with Patient E; **Found proved**
  - b. did not elicit an adequate medical history from Patient E, in that you did not elicit details of:
    - i. underlying causes of Patient E's abnormal ALT level;  
**Found proved**

- ii. Patient E's previous use of anabolic steroids;  
**Found proved**
  - c. did not perform any physical or mental health examination;  
**Found not proved**
  - d. inappropriately diagnosed Patient E with hypogonadism in that:
    - i. the diagnosis was contrary to laboratory results which showed normal gonadal function; **Found proved**
    - ii. you failed to consider any alternative diagnosis;  
**Found proved**
  - e. prescribed testosterone, hCG and mesterolone which was:
    - i. not clinically indicated; **Found proved**
    - ii. unsafe; **Found proved**
  - f. did not conduct tests adequately; **Found not proved**
  - g. did not review and adjust Patient E's treatment plan following concerns raised regarding symptoms of over-treatment of testosterone; **Found not proved**
  - h. did not adequately communicate with Patient E in that you delegated communications to non-medically trained members of staff when it was inappropriate to do so; **Found not proved**
  - i. did not maintain an adequate record throughout the period of treatment of Patient E. **Found proved**
22. The Consent Forms provided to Patient E stated that:
- a. the higher limit of normal testosterone range was 40 nmol/L;  
**Found proved**
  - b. untreated hypogonadism can increase the risk of:
    - i. heart disease; **Found proved**
    - ii. Alzheimer's disease; **Found proved**
    - iii. premature death; **Found proved**
  - c. the treatment provided was TRT; **Found proved**
  - d. Patient E will not take 'any type of anabolic steroid'. **Found proved**
23. You knew that the information in the Consent Forms was untrue as:

- a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **Found proved**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **Found not proved**
    - ii. Alzheimer's disease; **Found not proved**
    - iii. premature death; **Found not proved**
  - c. the treatment to be provided would increase testosterone above normal limits and was not TRT; **Found not proved**
  - d. you prescribed, or arranged to be prescribed, anabolic steroids to Patient E. **Found not proved**
24. Your conduct as set out at paragraph 22 was dishonest by reason of paragraph 23. **Found proved (in relation to 22a by reason of 23a)**
25. You did not obtain informed consent from Patient E for treatment you provided in that:
- a. you failed to counter-sign the Consent Forms; **Found not proved**
  - b. the Consent Forms contained statements which were untrue. **Found proved**

Patient F

26. Between October 2017 and December 2018, you failed to provide good clinical care to Patient F in that you:
- a. did not hold a consultation with Patient F; **Found proved**
  - b. did not elicit an adequate medical history from Patient F, in that you did not elicit details of:
    - i. sexual symptoms; **Found proved**
    - ii. non-sexual symptoms; **Found proved**
    - iii. answers to general health questions concerning the presenting complaint; **Found proved**
  - c. did not perform any physical or mental health examination of Patient F; **Found not proved**
  - d. prescribed testosterone:
    - i. which was inappropriate in that it was:

1. not clinically indicated; **Found proved**
  2. double the typical physiological replacement dose; **Found proved**
- e. did not conduct / arrange all necessary tests before prescribing medication to Patient F; **Found not proved**
  - f. did not adequately explain to Patient F how to safely administer the prescribed medication; **Found proved**
  - g. did not review Patient F's treatment plan; **Found proved**
  - h. did not adequately communicate with Patient F; **Found proved**
  - i. did not provide adequate follow up care; **Found proved**
  - j. did not obtain informed consent from Patient F in that you did not explain the risks and benefits of proposed treatment; **Found not proved**
  - k. did not maintain adequate medical records throughout the period of treatment of Patient F. **Found not proved**

#### Patient G

27. Between 6 December 2017 and 23 April 2018, you failed to provide good clinical care to Patient G in that you:
  - a. did not hold a consultation with Patient G; **Found proved**
  - b. did not elicit an adequate medical history from Patient G, in that you did not elicit details of:
    - i. sexual symptoms; **Found proved**
    - ii. non-sexual symptoms; **Found proved**
    - iii. answers to general health questions concerning the presenting complaint; **Found proved**
    - iv. Patient G's alcohol intake; **Found not proved**
  - c. did not perform any physical or mental health examination; **Found proved**
  - d. inappropriately diagnosed Patient G with hypogonadism in that:
    - i. the diagnosis was not supported by laboratory results; **Found proved**
    - ii. you failed to consider any alternative diagnosis; **Found proved**

- e. prescribed unlicensed testosterone cream and anastrozole which was:
    - i. not clinically indicated; **Found proved**
    - ii. unsafe; **Found proved**
    - iii. not recognised as therapeutic practice in medicine; **Found proved**
  - f. did not conduct tests adequately in that you failed to check Patient G's full blood count; **Found proved**
  - g. did not identify that repeat blood tests were contrary to your diagnosis of hypogonadism; **Found proved**
  - h. did not adequately communicate with Patient G; **Found proved**
  - i. did not provide adequate follow up care in that you:
    - i. failed to arrange a follow-up consultation with Patient G after treatment had commenced; **Found proved**
    - ii. delegated communications with Patient G to non-medically trained members of staff. **Found proved**
28. The Consent Forms provided to Patient G stated that:
- a. the higher limit of normal testosterone range was 40 nmol/L; **Found proved**
  - b. untreated hypogonadism can increase the risk of:
    - i. heart disease; **Found proved**
    - ii. Alzheimer's disease; **Found proved**
    - iii. premature death; **Found proved**
  - c. the treatment provided was TRT. **Found proved**
29. You knew that the information in the Consent Form was untrue as:
- a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **Found proved**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **Found not proved**
    - ii. Alzheimer's disease; **Found not proved**

- iii. premature death; **Found not proved**
  - c. the treatment to be provided would increase testosterone above normal limits and was not TRT. **Found not proved**
- 30. Your conduct as set out at paragraph 28 was dishonest by reason of paragraph 29. **Found proved (in relation 28a by reason of 29a)**
- 31. You did not obtain informed consent from Patient G for treatment you provided in that:
  - a. you failed to counter-sign the Consent Forms; **Found not proved**
  - b. the Consent Forms contained statements which were untrue. **Found proved**

Patient H

- 32. Between 28 December 2017 and 18 May 2018, you failed to provide good clinical care to Patient H in that you:
  - a. consulted with Patient H on 6 January 2018 and failed to:
    - i. elicit an adequate medical history in that you did not:
      - 1. elicit details of sexual symptoms: **Found not proved**
      - 2. elicit details of non-sexual symptoms; **Found not proved**
      - 3. ask general health questions concerning the presenting complaint; **Found not proved**
    - b. did not perform any physical or mental health examination; **Found not proved**
    - c. inappropriately diagnosed Patient H with hypogonadism in that:
      - i. the diagnosis was not supported by laboratory results; **Found proved**
      - ii. you failed to consider any alternative diagnosis; **Found proved**
    - d. prescribed testosterone propionate, hCG and anastrozole:
      - i. despite the fact that Patient H had expressly stated he did not want to compromise his fertility; **Found proved**
      - ii. which was:
        - 1. not clinically indicated; **Found proved**

2. unsafe; **Found proved**
  3. not recognised as therapeutic practice in medicine; **Found proved**
- e. did not conduct tests adequately in that you failed to:
- i. specify the conditions under which blood should be drawn; **Found not proved**
  - ii. arrange a repeat check of Patient H's full blood count; **Found proved**
- f. did not identify that subsequent test results evidenced signs of over treatment of testosterone; **Found not proved**
- g. did not adequately communicate with Patient H in that you failed to maintain regular correspondence; **Found proved**
- h. did not provide adequate follow up care in that you failed to arrange a follow-up consultation with Patient H after treatment had commenced. **Found proved**
33. The Consent Forms provided to Patient H stated that:
- a. the higher limit of normal testosterone range was 40 nmol/L; **Found proved**
  - b. untreated hypogonadism can increase the risk of:
    - i. heart disease; **Found proved**
    - ii. Alzheimer's disease; **Found proved**
    - iii. premature death; **Found proved**
  - c. the treatment provided was TRT. **Found proved**
34. You knew that the information in the Consent Forms was untrue as:
- a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **Found proved**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **Found not proved**
    - ii. Alzheimer's disease; **Found not proved**
    - iii. premature death; **Found not proved**

- c. the treatment to be provided would increase testosterone above normal limits and was not TRT. **Found not proved**
35. Your conduct as set out at paragraph 33 was dishonest by reason of paragraph 34. **Found proved (in relation on 33a in respect of 34a)**
36. You did not obtain informed consent from Patient H for treatment you provided in that:
- a. you failed to counter-sign the Consent Forms; **Found not proved**
  - b. the Consent Forms contained statements which were untrue. **Found proved**

Patient I

37. Between 5 January 2018 and 23 March 2018, you failed to provide good clinical care to Patient I in that you:
- a. consulted with Patient I on ~~31 January 2018~~ 30 January 2018 and failed to:
    - i. elicit an adequate medical history in that you:
      - 1. relied upon details obtained by a non-medically trained member of staff; **Found not proved**
      - 2. failed to elicit details of sexual symptoms; **Found not proved**
      - 3. failed to elicit details of non-sexual symptoms; **Found not proved**
    - ii. ask general health questions concerning the presenting complaint; **Found not proved**
  - b. did not perform any physical or mental health examination; **Found not proved**
  - c. inappropriately diagnosed Patient I with hypogonadism in that you failed to consider any:
    - i. alternative diagnosis; **Found not proved**
    - ii. likelihood that Patient I was seeking medication to build muscle mass rather than for therapeutic use; **Found not proved**
  - d. prescribed testosterone, anastrozole and mesterolone which was:
    - i. not clinically indicated; **Found proved**

- ii. unsafe; **Found proved**
- iii. not recognised as therapeutic practice in medicine; **Found proved**
- e. did not order any tests for Patient I:
  - i. before commencing treatment; **Found not proved**
  - ii. during treatment; **Found not proved**
- f. did not adequately communicate with Patient I in that you delegated communications to non-medically trained members of staff when it was inappropriate to do so; **Found not proved**
- g. did not provide adequate follow up care in that you:
  - i. failed to arrange a follow-up consultation with Patient I after treatment had commenced; **Found not proved**
  - ii. relied upon email communication between Patient I and non-clinical facilitators; **Found not proved**
- h. did not obtain informed consent from Patient I in that you failed to advise Patient I of:
  - i. the lack of evidence for therapeutic use for men with Patient I's presenting condition of the medication prescribed as set out at paragraph 37d; **Found not proved**
  - ii. the fact that the long-term risks associated with mesterolone treatment were unknown; **Found not proved**
  - iii. the risks associated with testosterone treatment; **Found not proved**
  - iv. the risks associated with anastrozole treatment; **Found not proved**

#### Patient J

38. Between 8 February 2018 and 7 November 2018, you failed to provide good clinical care to Patient J in that you:
- a. did not hold a consultation with Patient J; **Found proved**
  - b. did not elicit an adequate medical history, in that you failed to elicit details of:
    - i. history of anabolic steroid use; **Found proved**
    - ii. post cycle therapy; **Found proved**

- c. did not perform any physical or mental health examination of Patient J; **Found proved**
  - d. inappropriately diagnosed Patient J with hypogonadism in that:
    - i. you failed to consider any alternative diagnosis; **Found proved**
    - ii. laboratory evidence did not support a diagnosis of hypogonadism; **Found proved**
    - iii. you failed to adequately investigate whether Patient J was seeking the medication primarily for the purpose of muscle-building, rather than for any clinical need; **Found proved**
  - e. prescribed testosterone, hCG, exemestane and mesterolone which was:
    - i. not clinically-indicated; **Found proved**
    - ii. unsafe; **Found proved**
  - f. did not arrange all necessary tests for Patient J before reaching a diagnosis, including full blood count; **Found proved**
  - g. did not review Patient J's treatment plan when subsequent test results evidenced signs of over treatment of testosterone and hCG; **Found not proved**
  - h. did not adequately communicate with Patient J in that you failed to maintain regular correspondence; **Found not proved**
  - i. did not maintain adequate medical records throughout the period of treatment of Patient J. **Found not proved**
39. The Consent Forms provided to Patient J stated that:
- a. the higher limit of normal testosterone range was 40 nmol/L; **Found proved**
  - b. untreated hypogonadism can increase the risk of:
    - i. heart disease; **Found proved**
    - ii. Alzheimer's disease; **Found proved**
    - iii. premature death; **Found proved**
  - c. the treatment provided was TRT ; **Found proved**
  - d. Patient J will not take 'any type of anabolic steroid'. **Found proved**

40. You knew that the information in the Consent Forms was untrue as:
- a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **Found proved**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **Found not proved**
    - ii. Alzheimer's disease; **Found not proved**
    - iii. premature death; **Found not proved**
  - c. the treatment to be provided would increase testosterone above normal limits and was not TRT; **Found not proved**
  - d. you prescribed, or arranged to be prescribed, anabolic steroids to Patient J. **Found not proved**
41. Your conduct as set out at paragraph 39 was dishonest by reason of paragraph 40. **Found proved (in relation to 39a by reason of 40a)**
42. You did not obtain informed consent from Patient J for treatment you provided in that:
- a. you failed to counter-sign the Consent Forms; **Found not proved**
  - b. the Consent Forms contained statements which were untrue. **Found proved**

Patient K

43. Between 13 March 2018 and 7 September 2018, you failed to provide good clinical care to Patient K in that you:
- a. consulted with Patient K on 21 March 2018 and you did not elicit an adequate medical history in that you:
    - i. inappropriately relied upon details obtained by a non-medically trained member of staff; **Found not proved**
    - ii. failed to elicit details of sexual symptoms; **Found not proved**
    - iii. failed to elicit details of non-sexual symptoms; **Found not proved**
    - iv. failed to elicit details of Patient K's recent use of Clomiphene; **Found not proved**

- v. failed to recognise the degree of hypogonadal insufficiency based upon Patient K's previous diagnosis of testicular cancer; **Found not proved**
  - b. did not perform any physical or mental health examination; **Found proved**
  - c. diagnosed hypogonadism without identifying the correct sub-type of compensated primary hypogonadism; **Found proved**
  - d. prescribed testosterone, hCG and mesterolone which was:
    - i. not clinically-indicated; **Found proved**
    - ii. unsafe; **Found proved**
  - e. did not review and adjust Patient K's prescribed medication when laboratory results revealed excessively high testosterone levels; **Found proved**
  - f. did not adequately arrange repeat tests in that you failed to:
    - i. specify the conditions under which blood should be drawn; **Found not proved**
    - ii. check Patient K's full blood count; **Found proved**
  - g. did not adequately communicate with Patient K in that you delegated communications to non-medically trained members of staff when it was not appropriate to do so; **Found proved**
  - h. did not provide adequate follow up care in that you relied entirely upon email communication between Patient K and non-clinical facilitators; **Found not proved**
  - i. did not maintain an adequate record throughout the period of treatment of Patient K. **Found proved**
44. The Consent Forms provided to Patient K stated that:
- a. the higher limit of normal testosterone range was 40 nmol/L; **Found proved**
  - b. untreated hypogonadism can increase the risk of:
    - i. heart disease; **Found proved**
    - ii. Alzheimer's disease; **Found proved**
    - iii. premature death; **Found proved**
  - c. the treatment provided was TRT; **Found proved**

- d. Patient K will not take 'any type of anabolic steroid'. **Found proved**
45. You knew that the information in the Consent Forms was untrue as:
- a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **Found proved**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **Found not proved**
    - ii. Alzheimer's disease; **Found not proved**
    - iii. premature death; **Found not proved**
  - c. the treatment to be provided would increase testosterone above normal limits and was not TRT; **Found not proved**
  - d. you prescribed, or arranged to be prescribed, anabolic steroids to Patient K. **Found not proved**
46. Your conduct as set out at paragraph 44 was dishonest by reason of paragraph 45. **Found proved (in relation to 44a by reason of 45a)**
47. You did not obtain informed consent from Patient K for treatment you provided in that:
- a. you failed to counter-sign the Consent Forms; **Found not proved**
  - b. \_\_\_\_\_ the Consent Forms contained statements which were untrue. **Found proved**

#### Patient L

48. Between 8 March 2018 and 9 October 2018, you failed to provide good clinical care to Patient L in that you:
- a. consulted with Patient L on 8 March 2018 and failed to:
    - i. elicit an adequate medical history in that you did not elicit details of Patient C's L's:
      - 1. history of anabolic steroid use; **Found not proved**
      - 2. post-cycle therapy; **Found not proved**
    - ii. document basic clinical observations; **Found proved**
    - iii. adequately explain to Patient L:
      - 1. how to safely administer testosterone injections; **Found proved**

2. the risks associated with proposed treatment options;  
**Found proved**
- b. did not estimate Patient L's testicular volumes as part of a physical examination; **Found proved**
- c. inappropriately diagnosed Patient L with hypogonadism in that:
  - i. clinical evidence for hypogonadism was inadequately investigated; **Found proved**
  - ii. you failed to consider any alternative diagnosis;  
**Found proved**
  - iii. laboratory evidence did not support a diagnosis of hypogonadism; **Found proved**
- d. prescribed testosterone, hCG and mesterolone which was:
  - i. not clinically indicated; **Found proved**
  - ii. unsafe; **Found proved**
- e. did not adequately communicate with Patient L in that you:
  - i. failed to maintain regular contact during the course of Patient L's treatment; **Found proved**
  - ii. delegated communications with Patient L to non-medically trained staff when it was not appropriate to do so;  
**Found proved**
- f. did not review during treatment:
  - i. feedback from Patient L regarding his treatment;  
**Found proved**
  - ii. Patient L's laboratory results; **Found proved**
- g. did not provide any oversight to non-medical members of staff advising Patient L on clinical matters during his treatment;  
**Found not proved**
- h. following receipt of results which indicated treatment was ineffective, did not:
  - i. suspend or reduce medication; **Found proved**
  - ii. review the original diagnosis; **Found proved**
- i. did not arrange all necessary tests for Patient L; **Found proved**

- j. did not maintain adequate medical records throughout the period of treatment of Patient L. **Found proved**
49. The Consent Forms provided to Patient L stated that:
- a. the higher limit of normal testosterone range was 40 nmol/L; **Found proved**
  - b. untreated hypogonadism can increase the risk of:
    - i. heart disease; **Found proved**
    - ii. Alzheimer's disease; **Found proved**
    - iii. premature death; **Found proved**
  - c. the treatment provided was TRT; **Found proved**
  - d. Patient L will not take 'any type of anabolic steroid'. **Found proved**
50. You knew that the information in the Consent Form was untrue as:
- a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **Found proved**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **Found not proved**
    - ii. Alzheimer's disease; **Found not proved**
    - iii. Premature death; **Found not proved**
  - c. the treatment to be provided would increase testosterone above normal limits and was not TRT; **Found not proved**
  - d. you prescribed, or arranged to be prescribed, anabolic steroids to Patient L. **Found not proved**
51. Your conduct as set out at paragraph 49 was dishonest by reason of paragraph 50. **Found proved (in relation to 49a by reason of 50a)**
52. You did not obtain informed consent from Patient L for treatment you provided in that:
- a. you failed to counter-sign the Consent Forms; **Found not proved**
  - b. the Consent Forms contained statements which were untrue. **Found proved**

#### Patient M

53. Between March 2018 and 31 August 2018, you failed to provide good clinical care to Patient M in that you:
- a. consulted with Patient M on 24 April 2018 and failed to elicit an adequate medical history in that you:
    - i. relied upon details obtained by a non-medically trained member of staff; **Found not proved**
    - ii. failed to elicit details of sexual symptoms; **Found not proved**
    - iii. failed to elicit details of non-sexual symptoms; **Found not proved**
  - b. did not perform any physical or mental health examination; **Found not proved**
  - c. inappropriately diagnosed Patient M with hypogonadism in that:
    - i. the diagnosis was not supported by laboratory results; **Found proved**
    - ii. you failed to consider any alternative diagnosis; **Found proved**
    - iii. you failed to refer to evidence which suggested Patient M was seeking medication for androgen abuse; **Found not proved**
  - d. prescribed testosterone and mesterolone which was:
    - i. not clinically indicated; **Found proved**
    - ii. unsafe; **Found proved**
  - e. did not conduct tests adequately in that you failed to:
    - i. specify the conditions under which blood should be drawn; **Found not proved**
    - ii. check Patient M's full blood count for haematocrit; **Found proved**
  - f. did not review Patient M's treatment plan when subsequent test results evidenced signs of over treatment of testosterone; **Found not proved**
  - g. did not adequately communicate with Patient M in that you delegated communications to non-medically trained members of staff when it was inappropriate to do so. **Found proved**
54. The Consent Forms provided to Patient M stated that:

- a. the higher limit of normal testosterone range was 40 nmol/L; **Found proved**
  - b. untreated hypogonadism can increase the risk of:
    - i. heart disease; **Found proved**
    - ii. Alzheimer's disease; **Found proved**
    - iii. premature death; **Found proved**
  - c. the treatment provided was TRT; **Found proved**
  - d. Patient M will not take 'any type of anabolic steroid'. **Found proved**
55. You knew that the information in the Consent Forms was untrue as:
- a. 40 nmol/L exceeded laboratory normal ranges for testosterone; **Found proved**
  - b. there was a lack of evidence that untreated hypogonadism increased the risk of:
    - i. heart disease; **Found not proved**
    - ii. Alzheimer's disease; **Found not proved**
    - iii. premature death; **Found not proved**
  - c. the treatment to be provided would increase testosterone above normal limits and was not TRT; **Found not proved**
  - d. you prescribed, or arranged to be prescribed, anabolic steroids to Patient M. **Found not proved**
56. Your conduct as set out at paragraph 54 was dishonest by reason of paragraph 55. **Found proved (in relation to 54a by reason of 55a)**
57. You did not obtain informed consent from Patient M for treatment you provided in that:
- a. you failed to counter-sign the Consent Forms; **Found not proved**
  - b. the Consent Forms contained statements which were untrue. **Found proved**

Patient N

58. Between 25 April 2018 and 19 November 2018, you failed to provide good clinical care to Patient N in that you:
- a. did not hold a consultation with Patient N; **Found proved**

- b. did not elicit an adequate medical history in that you did not elicit details of:
  - i. sexual symptoms; **Found proved**
  - ii. non-sexual symptoms; **Found proved**
  - iii. answers to general health questions concerning the presenting complaint; **Found proved**
- c. relied upon the responses of Patient N to inadequate email enquiries as the basis for clinical decision-making; **Found proved**
- d. did not perform any physical or mental health examination of Patient N; **Found proved**
- e. inappropriately diagnosed Patient N with hypogonadism in that:
  - i. the diagnosis was contrary to laboratory results; **Found proved**
  - ii. you failed to consider any underlying causes for the laboratory results; **Found proved**
  - iii. you failed to consider any alternative diagnosis; **Found proved**
- f. prescribed Patient N with testosterone:
  - i. which was:
    - 1. not clinically indicated; **Found proved**
    - 2. unsafe; **Found proved**
  - ii. without explaining the risks and benefits to Patient N; **Found proved**
- g. increased the original dosage of prescribed testosterone from 11.9 mg/day to 25mg/day:
  - i. without any clinical basis for doing so; **Found proved**
  - ii. when Patient N suggested seeking the services of another provider if the dosage wasn't increased; **Found proved**
  - iii. knowing that in doing so you were supporting Patient N's abuse of testosterone medication; **Found proved**
- h. did not adequately communicate with Patient N in that you did not:
  - i. maintain regular contact during the course of Patient N's treatment; **Found proved**

- ii. respond to concerns raised by Patient N in July 2018 relating to symptoms characteristic of over treatment of testosterone; **Found proved**
- iii. delegated communications with Patient N to non-medically trained staff when it was not appropriate to do so; **Found proved**
- i. did not provide any oversight on clinical matters to non-medical members of staff advising Patient N during his treatment; **Found not proved**
- j. inappropriately agreed not to inform Patient N's general practitioner of your care and treatment; **Found not proved**
- k. did not review:
  - i. Patient N's further laboratory results received once treatment commenced; **Found proved**
  - ii. Patient N's treatment plan following concerns raised regarding possible over treatment of testosterone as set out at paragraph 58h.ii above; **Found proved**
- l. did not maintain adequate medical records throughout the period of treatment of Patient N. **Found proved**

#### Patient O

59. Between 15 May 2018 and 29 December 2018, you failed to provide good clinical care to Patient O in that you:
- a. consulted with Patient O on 15 May 2018 and you did not elicit an adequate medical history in that you:
    - i. inappropriately relied upon details obtained by a non-medically trained member of staff; **Found not proved**
    - ii. failed to reconcile contradictory statements given by Patient O previously regarding his medical history; **Found not proved**
    - iii. failed to ask any general health questions concerning the presenting complaint; **Found not proved**
    - iv. failed to elicit details of Patient O's psychological background; **Found not proved**
  - b. diagnosed Patient O with hypogonadism when laboratory evidence did not support a diagnosis of hypogonadism; **Found proved**
  - c. did not perform any physical or mental health examination of Patient O; **Found not proved**

- d. did not conduct / arrange a full blood count before prescribing medication to Patient O; **Found proved**
- e. prescribed testosterone, anastrozole, mesterolone and tamoxifen which was:
  - i. not clinically indicated; **Found proved**
  - ii. unsafe; **Found proved**
  - iii. not recognised as therapeutic practice in medicine; **Found proved**
- f. did not make the necessary changes to Patient O's medication when he started to exhibit symptoms associated with over-prescribing of testosterone in that you:
  - i. failed to reduce Patient O's testosterone medication far enough; **Found proved**
  - ii. escalated the dosage of oestrogen blockers; **Found proved**
- g. did not adequately communicate with Patient O in that you failed to maintain regular correspondence; **Found proved**
- h. did not maintain adequate medical records throughout the period of treatment of Patient O; **Found not proved**
- i. did not obtain informed consent from Patient O in that:
  - i. the information provided to Patient O before treatment was:
    - 1. inaccurate; **Found not proved**
    - 2. misleading; **Found not proved**
  - ii. the Consent Forms for:
    - 1. the treatment plan was not counter-signed by Patient O; **Found not proved**
    - 2. electronic communication was not signed by either yourself or Patient O. **Found not proved**

#### Patient P

60. In September 2018, you failed to provide good clinical care to Patient P in that you:
- a. did not hold a consultation with Patient P; **Found proved**
  - b. did not elicit an adequate medical history from Patient P, in that you did not elicit details of:

- i. sexual symptoms; **Found proved**
- ii. non-sexual symptoms; **Found proved**
- iii. answers to general systems-orientated questions; **Found proved**
- c. did not perform any physical or mental health examination of Patient P; **Found not proved**
- d. prescribed testosterone, hCG and anastrozole:
  - i. which was inappropriate in that it was:
    - 1. not clinically indicated; **Found proved**
    - 2. unsafe; **Found proved**
    - 3. not recognised as therapeutic practice in medicine; **Found proved**
  - ii. without explaining the risks and benefits to Patient P; **Found proved**
- e. did not conduct / arrange all necessary tests before prescribing medication to Patient P; **Found not proved**
- f. did not review Patient P's treatment plan; **Found not proved**
- g. did not communicate at all with Patient P during the course of his treatment; **Found proved**
- h. did not provide adequate follow up care; **Found not proved**
- i. did not maintain adequate medical records throughout the period of treatment of Patient P. **Found not proved**

#### Patient Q

61. In November 2018, you failed to provide good clinical care to Patient Q in that you:
- a. did not hold a consultation with Patient Q; **Found proved**
  - b. did not elicit an adequate medical history from Patient Q, in that you did not elicit details of:
    - i. sexual symptoms; **Found proved**
    - ii. non-sexual symptoms; **Found proved**
    - iii. answers to general health questions concerning the presenting complaint; **Found proved**

- c. did not perform any physical or mental health examination of Patient Q; **Found not proved**
- d. prescribed testosterone and anastrozole:
  - i. which was inappropriate in that it was:
    - 1. not clinically indicated;  
**Found not proved in relation to testosterone**  
**Found proved in relation to anastrozole**
    - 2. unsafe;  
**Found not proved in relation to testosterone**  
**Found proved in relation to anastrozole**
    - 3. not recognised as therapeutic practice in medicine;  
**Found not proved in relation to testosterone**  
**Found proved in relation to anastrozole**
  - ii. without explaining the risks and benefits to Patient Q;  
**Found not proved**
- e. did not conduct / arrange all necessary tests before prescribing medication to Patient Q; **Found not proved**
- f. did not adequately communicate with Patient Q in that you delegated communications to non-medically trained members of staff when it was inappropriate to do so; **Found proved**
- g. did not review Patient Q's treatment plan; **Found not proved**
- h. did not provide adequate follow up care; **Found proved**
- i. did not maintain adequate medical records throughout the period of treatment of Patient Q. **Found not proved**

#### Patient R

- 62. Between November 2018 and March 2019, you failed to provide good clinical care to Patient R in that you:
  - a. did not hold a face-to-face consultation with Patient R;  
**Found not proved**
  - b. did not elicit an adequate medical history from Patient R, in that you did not elicit details of:
    - i. sexual symptoms; **Found not proved**
    - ii. non-sexual symptoms; **Found not proved**

- iii. answers to general health questions concerning the presenting complaint; **Found not proved**
    - c. did not perform any physical / mental state examination of Patient R; **Found not proved**
    - d. prescribed testosterone, hCG and anastrozole:
      - i. which was inappropriate in that it was:
        - 1. not clinically indicated; **Found not proved**
        - 2. unsafe; **Found not proved**
        - 3. not recognised as therapeutic practice in medicine; **Found not proved**
      - ii. without explaining the risks and benefits to Patient R; **Found not proved**
    - e. did not conduct / arrange all necessary tests before prescribing medication to Patient R; **Found not proved**
    - f. did not review Patient R's treatment plan; **Found not proved**
    - g. did not provide adequate follow up care; **Found not proved**
    - h. did not maintain adequate medical records throughout the period of treatment of Patient R. **Found not proved**
63. The treatment to the patients as set out at paragraphs 1 - 62 above was:
- a. provided:
    - i. outside the limits of your expertise as a consultant gastroenterologist; **Found proved**
    - ii. whilst failing to adhere to national and international guidelines; **Found not proved**
    - iii. without the necessary qualifications, training and experience; **Found proved**
    - iv. whilst exposing them to risks of:
      - 1. androgen toxicity, including: **Found proved**
      - 2. testosterone-induced erythrocytosis; **Found proved**
    - v. knowing or believing that it was to be used by the patients for reasons not based on any clinical need; **Found not proved**

- b. financially motivated. **Found proved**

## **Transgender Patients**

### Patient S

- 64. Between February 2017 and November 2018, you failed to provide good clinical care to Patient S in that you:
  - a. did not establish an adequate Multi-Disciplinary Team ('MDT'); **Found proved**
  - b. did not conduct any:
    - i. physical assessment; **Found proved**
    - ii. face-to-face or video consultation with Patient S; **Found proved**
  - c. relied upon an inadequate mental health assessment in that you:
    - i. relied entirely upon the opinions of counsellors:
      - 1. without adequate qualifications; **Found not proved**
      - 2. without registration with a recognised regulatory body; **Found not proved**
      - 3. who conducted a telephone interview of unknown quality or duration; **Found proved**
      - 4. who produced a report which you should have recognised was not sufficiently detailed; **Found proved**
    - ii. did not liaise with Patient S's mental health workers; **Found proved**
    - iii. did not engage with Patient S's mental health workers when they actively sought to communicate with you; **Found proved**
    - iv. did not ensure the assessment process was adapted to account for Patient S's needs; **Found proved**
  - d. reached a diagnosis of gender dysphoria based upon findings resulting from your inadequate assessment as set out at paragraphs 64b – c above; **Found proved**
  - e. prescribed oestrogen and anti-androgens to Patient S without:

- i. being able to ensure it was clinically-indicated;  
**Found proved**
- ii. adequately monitoring, throughout the course of treatment, Patient S's:
  - 1. physical response to treatment; **Found proved**
  - 2. psychosocial response to treatment; **Found proved**
- iii. discussing alternative treatments with Patient S;  
**Found proved**
- f. continued to prescribe oestrogen to Patient S despite evidence that:
  - i. the dose was excessive; **Found proved**
  - ii. Patient S was starting to experience known risks;  
**Found proved**
- g. did not directly notify Patient S's GP, Dr ML, regarding any treatment you prescribed to Patient S; **Found proved**
- h. did not make any changes to your clinical management of Patient S when they:
  - i. failed to obtain blood results upon request; **Found proved**
  - ii. failed to check their blood pressure upon request;  
**Found proved**
  - iii. returned abnormal results in relation to paragraph 64h.i – ii;  
**Found not proved**
- i. did not seek to conduct any follow up consultation between Patient S and:
  - i. yourself; **Found proved**
  - ii. an appropriately qualified person; **Found not proved**
- j. did not adequately communicate with Patient S in that you:
  - i. did not contact Patient S with adequate frequency throughout their period of treatment; **Found proved**
  - ii. inappropriately delegated communications to:
    - 1. administrative staff; **Found proved**
    - 2. counsellors; **Found proved**

- iii. failed to adapt communications appropriately to take into account the fact that Patient S is on the autistic spectrum; **Found proved**
  - k. did not obtain informed consent in that you:
    - i. did not adequately assess Patient S's capacity to consent; **Found proved**
    - ii. failed to counter-sign the consent form; **Found not proved**
    - iii. commenced treatment without Patient S having signed the consent form. **Found not proved**
65. You provided treatment to Patient S as outlined at paragraph 64 above:
- a. outside the limits of your expertise as a consultant gastroenterologist; **Found proved**
  - b. without the necessary qualifications and training and experience in:
    - i. transgender medicine; **Found proved**
    - ii. assessing capacity and autonomy in an adolescent with mental health issues; **Found proved**
  - c. whilst failing to adhere to a recognised training pathway in transgender medicine. **Found proved**

#### Patient T

66. Between May 2017 and January 2018, you failed to provide good clinical care in that you:
- a. did not establish an adequate MDT; **Found proved**
  - b. did not advise Patient T's GP ('Dr DP') that you had taken over the care of Patient T from Dr HW; **Found not proved**
  - c. sought a shared-care agreement with Dr DP which was inappropriate in that you were unqualified to:
    - i. autonomously prescribe to minors; **Found proved**
    - ii. sign-off on shared-care agreement involving minors; **Found proved**
  - d. continued to prescribe injections of gonadotrophin releasing-hormone ('GnRH') off-licence to Patient T without:
    - i. up to date blood tests; **Found proved**

- ii. any periodic appraisals of Patient T's condition through face-to-face or video consultations; **Found proved**
  - e. did not arrange an assessment of Patient T by an appropriately qualified expert in transgender minors; **Found proved**
  - f. did not recognise that the initial psychological assessment was insufficiently detailed; **Found proved**
  - g. review Patient T's consent to treatment when it was apparent that:
    - i. not all risks had been discussed with Patient T; **Found not proved**
    - ii. Patient T's capacity to consent had not been adequately considered; **Found not proved**
    - iii. Patient T's consent form had been received remotely, not affording them the opportunity to ask questions; **Found not proved**
  - h. inappropriately relied solely on Patient T's mother to provide updates relating to Patient T's condition. **Found proved**
67. You provided treatment to Patient T as outlined at paragraph 66 above:
- a. on behalf of Dr HW whilst she was subject to an interim order of suspension; **Found not proved**
  - b. outside the limits of your expertise as a consultant gastroenterologist; **Found proved**
  - c. without the necessary qualifications and training in:
    - i. paediatrics; **Found proved**
    - ii. general practice; **Found proved**
    - iii. clinical management of a minor; **Found proved**
  - d. whilst failing to adhere to a recognised training pathway in transgender medicine. **Found proved**

#### Patient U

68. Between May 2017 and July 2018, you failed to provide good clinical care to Patient U in that you:
- a. did not establish an adequate MDT; **Found proved**
  - b. diagnosed Patient U with gender dysphoria on 15 July 2017:

- i. without any face-to-face or video consultations with Patient U; **Found not proved**
  - ii. without receiving any information from Patient U's GP to corroborate information received from Patient U via the online questionnaire completed on 23 May 2017; **Found proved**
  - iii. based upon psychological assessments from counsellors:
    - 1. who were unregulated; **Found not proved**
    - 2. who had never met Patient U; **Found proved**
    - 3. which you should have recognised were insufficiently detailed; **Found proved**
  - c. prescribed private prescriptions of Testosterone Gel ('TestoGel') between 28 June 2017 and 30 May 2018, each of eight weeks' supply, which was not clinically indicated in that you:
    - i. had not received relevant information from Patient U's GP; **Found proved**
    - ii. did not communicate with Patient U's mental health workers beforehand; **Found proved**
  - d. did not ensure informed consent had been obtained from Patient U in that you:
    - i. only obtained consent remotely and did not allow Patient U the opportunity to engage with you personally to discuss risks and benefits of treatment; **Found proved**
    - ii. inadequately assessed Patient U's understanding of the risks and benefits of treatment in that you only asked them to provide a written summary; **Found proved**
    - iii. did not inform yourself of Patient U's involvement with mental health workers, specifically:
      - 1. the mental health workers' concerns regarding gender affirming treatment; **Found proved**
      - 2. Patient U's capacity to provide informed consent. **Found proved**
69. On 21 September 2017, when Patient U was temporarily uncontactable, you failed to:
- a. suspend Patient U's gender-affirming treatment, including administration of TestoGel; **Found proved**

- b. advise the following that the gender-affirming treatment, including administration of TestoGel, should be suspended:
    - i. Patient U; **Found proved**
    - ii. Patient U's GP. **Found proved**
70. You continued to prescribe eight weeks' supply of TestoGel to Patient U even though you:
- a. learned that CMHT had previously disagreed with TestoGel treatment; **Found not proved**
  - b. had reasons to believe that Patient U was regularly over-dosing on the prescribed TestoGel. **Found not proved**
71. You provided treatment to Patient U as outlined at paragraph 68 - 70 above:
- a. outside the limits of your expertise as a consultant gastroenterologist; **Found proved**
  - b. without the necessary qualifications and training in general practice; **Found proved**
  - c. whilst failing to adhere to a recognised training pathway in transgender medicine. **Found proved**

#### Patient V

72. Between May 2018 and October 2018, you failed to provide good clinical care to Patient V in that you:
- a. did not establish an adequate MDT; **Found proved**
  - b. diagnosed Patient V as suffering from gender dysphoria in July 2018:
    - i. based upon a questionnaire which was inadequate for assessment of a minor; **Found proved**
    - ii. without performing an adequate:
      - 1. mental state examination; **Found proved**
      - 2. physical examination; **Found proved**
  - c. started to prescribe GnRH-antagonist ('GnRHa') injections off-licence to Patient V on ~~18 July 2018~~ 16 July 2018 without;
    - i. blood test results to confirm biochemical puberty; **Found proved**
    - ii. arranging a baseline bone density scan; **Found not proved**

- iii. considering alternative treatments; **Found proved**
- iv. being able to adequately assess the balance between the risks and benefits of prescribing GnRHa to Patient V; **Found proved**
- v. adequately advising of the risks to Patient V's parents; **Found proved**
- vi. informing Dr K, Patient V's GP; **Found proved**
- d. continued to prescribe GnRHa to Patient V without first conducting a period of assessment over several months; **Found proved**
- e. did not obtain informed consent from Patient V in that you:
  - i. did not adequately assess Patient V as being Gillick competent; **Found proved**
  - ii. in the alternative to Paragraph 72e.i, did not record how you reached the conclusion that Patient V was Gillick competent; **Found not proved**
  - iii. failed to discuss the full risks and benefits of treatment with Patient V directly; **Found proved**
- f. did not obtain informed consent from Patient V's parents on 29 June 2018 in that:
  - i. you obtained consent for testosterone treatment seven years before Patient V could receive it; **Found not proved**
  - ii. you did not counter-sign the leaflet provided to Patient V's parents detailing the intended treatment ('the Leaflet'); **Found not proved**
  - iii. the Leaflet incorrectly advised that hormone blockers are fully reversible; **Found not proved**
- g. provided information ('the Information') to Patient V's parents which:
  - i. failed to declare:
    - 1. your lack of qualifications to manage the care of minors; **Found not proved**
    - 2. that Dr HW was no longer a credible MDT member as she was subject to an interim order of suspension; **Found not proved**
  - ii. detailed an inadequate MDT make-up; **Found not proved**

- iii. stated that:
  - 1. GnRHa was required to entirely prevent the onset of puberty in suspected transgender minors, which is contrary to expert guidance; **Found not proved**
  - 2. there was a 50% risk of attempted suicide in young transgender clients, which was not based upon UK statistics; **Found not proved**
  - 3. Dr TS was a Consultant Clinical Psychologist, when she was a qualified counsellor; **Found not proved**
  - 4. Dr VP was a Consultant Clinical Psychologist, when she was a registered Counselling Psychologist; **Found not proved**
- iv. made incorrect statements about NHS transgender services, including that:
  - 1. the ‘minimum expected wait for treatment is likely to be five and a half years’; **Found not proved**
  - 2. as a consequence of delay, transgender minors would necessarily require more extensive surgery in the future; **Found not proved**
- v. incorrectly advised that:
  - 1. hormone blockers were ‘fully reversible’; **Found not proved**
  - 2. testosterone could be prescribed to patients under 16 in exceptional circumstances. **Found not proved**

73. The distribution of the Information was:

- a. done in order to persuade Patient V’s parents to use Gender GP for the care and treatment of Patient V; **Found not proved**
- b. financially motivated. **Found not proved**

74. You provided treatment to Patient V as outlined at paragraph 72 above:

- a. outside the limits of your expertise as a consultant gastroenterologist; **Found proved**
- b. without the necessary qualifications and training in:
  - i. paediatrics; **Found proved**
  - ii. general practice; **Found proved**

- iii. clinical management of a minor; **Found proved**
- c. whilst failing to adhere to a recognised training pathway in transgender medicine. **Found proved**

Patient W

75. Between June 2018 and September 2018, you failed to provide good medical care to Patient W in that you:

- a. diagnosed Patient W with gender dysphoria and did not:
  - i. establish an adequate MDT; **Found proved**
  - ii. carry out any face-to-face consultations with Patient W; **Found not proved**
  - iii. carry out an adequate:
    - 1. physical examination; **Found not proved**
    - 2. mental state examination; **Found proved**
  - iv. corroborate any of the information provided to you by Patient W with:
    - 1. Patient W's GP, Dr GY; **Found proved**
    - 2. Patient W's mental health workers; **Found proved**
    - 3. the nurse at Patient W's school; **Found proved**
  - v. seek further information regarding Patient W's mental health from:
    - 1. Dr GY; **Found proved**
    - 2. Patient W's mental health workers; **Found proved**
    - 3. the nurse at Patient W's school; **Found proved**
- b. prescribed testosterone to Patient W:
  - i. which was not clinically-indicated; **Found proved**
  - ii. without first establishing whether the risks of prescribing testosterone were lower than the risks to Patient W's mental and physical health if not prescribed; **Found proved**
  - iii. before entering into a shared care agreement with Dr GY; **Found not proved**

- iv. without informing Dr GY that you had commenced testosterone treatment; **Found not proved**
  - c. did not record any details as to the prescribing of testosterone to Patient W, including:
    - i. dosage; **Found not proved**
    - ii. date of prescription; **Found not proved**
  - d. did not obtain informed consent from Patient W in that you:
    - i. failed to countersign the consent form; **Found not proved**
    - ii. provided no details as to the verbal consenting process, including whether appropriate communication in dealing with a patient with autism was employed; **Found not proved**
  - e. did not provide adequate follow up care. **Found not proved**
76. You provided treatment to Patient W as outlined at paragraph 75 above:
- a. outside the limits of your expertise as a consultant gastroenterologist; **Found proved**
  - b. without the necessary qualifications and training and experience in transgender medicine; **Found proved**
  - c. whilst failing to adhere to a recognised training pathway in transgender medicine. **Found proved**

Patient X

77. Between August 2018 and June 2019, you failed to provide good clinical care to Patient X in that you:
- a. did not establish an adequate MDT; **Found proved**
  - b. diagnosed Patient X with gender dysphoria:
    - i. without any face-to-face or video consultations with Patient X; **Found proved**
    - ii. based upon physical and psychological assessments:
      - 1. from unqualified staff; **Found not proved**
      - 2. which you should have recognised were insufficiently detailed; **Found proved**
    - iii. without obtaining an adequate medical history; **Found proved**

- c. prescribed a 12-week supply of oestradiol patches (100 mcg, twice weekly), micronized progesterone (100 mg, daily) and spironolactone (100 mg daily) to Patient X in March 2019 without:
  - i. any personal contact with Patient X during the course of treatment; **Found proved**
  - ii. obtaining a basic medical history; **Found proved**
  - iii. carrying out a:
    - 1. physical state examination; **Found proved**
    - 2. mental state examination; **Found proved**
  - iv. an adequate discussion with Patient X about the risks and benefits of treatment; **Found proved**
  - v. considering Patient X's baseline investigations beforehand; **Found not proved**
  - vi. recording the basis for the prescription; **Found not proved**
  - vii. a plan for holistic review of Patient X's progress apart from blood tests; **Found proved**
- d. prescribed micronized progesterone:
  - i. contrary to guidance; **Found proved**
  - ii. without evidence of any benefit to Patient X; **Found proved**
  - iii. which increased the risks to Patient X of:
    - 1. impaired breast development; **Found proved**
    - 2. venous thrombo-embolism; **Found proved**
    - 3. breast cancer; **Found proved**
- e. did not keep any records of your care and treatment of Patient X; **Found not proved**
- f. did not obtain informed consent from Patient X in that you:
  - i. failed to directly contribute to the consenting process with Patient X; **Found not proved**
  - ii. failed to counter-sign the consent documentation; **Found not proved**

- iii. obtained consent remotely which did not allow Patient X the opportunity to engage with you personally to discuss risks and benefits of treatment; **Found proved**
  - iv. failed to adequately assess Patient X's capacity in light of their mental health concerns. **Found proved**
78. Your conduct as described at paragraphs 77c – e above was in breach of the interim order of conditions imposed upon your registration during the period of time you treated Patient X. **Found not proved**
79. You provided treatment to Patient X as outlined at paragraph 77 above:
- a. outside the limits of your expertise as a consultant gastroenterologist; **Found proved**
  - b. without the necessary qualifications and training and experience in transgender medicine; **Found proved**
  - c. whilst failing to adhere to a recognised training pathway in transgender medicine. **Found proved**

#### Patient Y

80. Between 15 October 2018 and 22 March 2019, you failed to provide good clinical care to Patient Y in that you:
- a. did not establish an adequate MDT; **Found proved**
  - b. diagnosed Patient Y as suffering from gender dysphoria based solely upon:
    - i. Patient Y's answers to Gender GP questionnaires without further investigation; **Found not proved**
    - ii. the content of Patient Y's emails in exchanges with Gender GP staff who lacked the necessary qualifications in mental or physical healthcare; **Found not proved**
    - iii. a report by a counsellor who:
      - 1. lacked adequate qualifications to reach a clinical diagnosis of gender dysphoria; **Found not proved**
      - 2. only engaged with Patient Y in a single 20-minute video consultation; **Found not proved**
    - iv. a 30-minute consultation with Patient Y by a registered nurse who failed to keep a formal record of that consultation; **Found not proved**
  - c. did not conduct any examination yourself, including that you did not:

- i. elicit a face-to-face medical history; **Found proved**
- ii. conduct a mental state examination; **Found proved**
- iii. obtain basic clinical observations; **Found proved**
- d. allowed Patient Y to be prescribed cross-hormone testosterone treatment:
  - i. by individuals who were not recognised specialists in transgender medicine; **Found proved**
  - ii. without any personal consultation with Patient Y in order to:
    - 1. elicit a basic medical history; **Found proved**
    - 2. conduct a physical state examination; **Found proved**
    - 3. conduct a mental state examination; **Found proved**
    - 4. discuss risks and benefits of proposed treatment; **Found proved**
- e. did not advise Patient Y or any of Patient Y's GPs during the period of treatment through Gender GP that you were not directly prescribing to Patient Y; **Found proved**
- f. did not plan to review Patient Y throughout the period of treatment in order to periodically assess their:
  - i. physical wellbeing; **Found proved**
  - ii. mental wellbeing; **Found proved**
  - iii. feelings towards anticipated changes resulting from hormone therapy; **Found proved**
- g. did not adjust the testosterone prescriptions for Patient Y when blood results showed that Patient Y had:
  - i. nearly twice the upper limit of testosterone in the normal male reference range; **Found proved**
  - ii. developed abnormalities in their red blood cell morphology; **Found proved**
- h. did not establish a treatment plan for Patient Y, including:
  - i. arrangements for face-to-face reviews every three to four months; **Found proved**

- ii. target ranges to be achieved for blood test results;  
**Found proved**
  - i. did not liaise with Patient Y's mental health workers;  
**Found not proved**
  - j. did not personally participate in the process of obtaining consent from Patient Y in that you failed to:
    - i. contemporaneously counter-sign Patient Y's consent to treatment form; **Found not proved**
    - ii. give Patient Y the opportunity to discuss risks and benefits of the proposed treatment with you; **Found proved**
  - k. did not maintain you own medical records for Patent Y.  
**Found not proved**
81. You provided treatment to Patient Y as outlined at paragraph 80 above:
- a. outside the limits of your expertise as a consultant gastroenterologist; **Found proved**
  - b. without the necessary qualifications and training and experience in transgender medicine; **Found proved**
  - c. whilst failing to adhere to a recognised training pathway in transgender medicine. **Found proved**
82. Your actions as described at one or more of paragraphs 64 - 81 were outwith UK guidance in that they were contrary to the NHS Standard Contract for Gender Identity Development Service for Children and Adolescents issued in 2016. **Found not proved**

### **Gender GP**

83. Until 2019, alongside Dr HW, you operated and controlled the company known as Gender GP, through which you provided care and treatment as stated at paragraphs 64 – 82 above. **Found proved**
84. In 2019, on the governance page of the Gender GP website it stated that 'all medical advice and prescriptions are provided by doctors working outside of the UK'. **Found proved**
85. The operating method of Gender GP as described at paragraph 84 above was motivated by efforts to avoid the regulatory framework of the United Kingdom, including regulation by the:
- a. CQC; **Found proved**
  - b. HIW. **Found proved**

86. In November 2018:
- a. the only General Practitioner at Gender GP, Dr HW, was subject to an interim order of suspension ('the IOT Order'); **Found proved**
  - b. there were no other GPs practising as part of Gender GP.  
**Found proved**
87. You knew that following the IOT Order:
- a. Dr HW was unable to participate in the work of Gender GP in her capacity as General Practitioner; **Found proved**
  - b. there were no other GPs practising as part of Gender GP.  
**Found proved**
88. Following the IOT Order you retained the name of your company as Gender GP. **Found proved**
89. Your conduct as outlined at paragraph 88 above was dishonest by reason paragraphs 86 and 87. **Found not proved**