> mother, it is not satisfied that this is sufficient in relation to the risks and consequences upon fertility of what is life changing treatment. Further, the Tribunal has not been provided with any contemporaneous notes or objective evidence to be satisfied Dr Webberley discussed the risks to Patient C's fertility."

137. Given that I have notionally excised paras 585-586, this is obviously the key paragraph. Here, the MPT appear to be saying three things. First, that in the email correspondence the likelihood of proceeding from stage 1 to stage 2 was not spelt out. In reaching that interpretation of a sentence which is elliptically expressed, I am reading it in conjunction with para 586 and the GMC's closing arguments. Secondly, Patient C (and/or his mother) was not advised of the fertility risks from taking gender-affirming hormones, being the likely consequence of beginning this treatment. Thirdly (and giving the most favourable interpretation of the form from the MPT's perspective), that there was in any event no discussion with Patient C himself.

138. There are obvious difficulties with this paragraph. First, it fails to address the key email sent, on the evidence before the MPT, by the administrative assistant on the Appellant's instructions. Secondly, it takes the false point that there was an obligation to explain in express terms the likelihood of moving to the next stage; the duty in my judgment was lower than that. Thirdly, the reasoning process is in the wrong order. The final sentence of para 588 should have been at the start. Throughout, the MPT did not follow Mr Mant's sequencing or, indeed, my preferred sequencing.

139. However, I am not persuaded that I should be allowing this appeal on the basis that para 588 is poorly reasoned. It is an inescapable fact that that there was no discussion of the fertility risks with Patient C as there ought to have been. Whether that omission amounted to a want of good clinical care in the light of the discussions that *did* take place (and which were not as it happens properly analysed by the MPT) does not demand my concluded view. This issue is better considered, without creating any prejudice to the Appellant or the Respondent, alongside the MPT's findings on serious misconduct.

140. I therefore move forward to paras 120-122 of the MPT determination on misconduct, which as I have said was handed down at the same time as its determination on impairment. These paragraphs provide:

> "120. The Tribunal was mindful of the point that the moment to which the charge relates was not the last opportunity for Dr Webberley to discuss the risks to fertility with Patient C, although it did recognise the point that the vast majority of patients who are treated with GnRHa go on to take gender affirming hormones. It also noted that Dr Webberley was aware of her omission and sought to correct it when she wrote to Patient C's mother on 26 February 2017, but this was long after the consultation which took place on 9 November 2016 and significantly before Dr Webberley wrote the prescription on 29 April 2017.
>
> 121. The Tribunal considered that the probable permanent suppression of fertility was a matter which ought to have been

> raised by Dr Webberley with Patient C at the time of the consultation. It recognised that puberty suppression is reversible, and that discussing fertility with a young person is difficult, and that it takes time for a person to think through such weighty matters. However, it is in evidence that most patients opting for puberty suppression will later request GAH. Therefore, the initial consultation was a key juncture; Dr Webberley should have started the ball rolling in respect of fertility so that Patient C could have time to absorb the information and reflect on it.
>
> 122. In the circumstances, the Tribunal find that Dr Webberley's omission to discuss the risks to Patient C's fertility before commencing treatment amounted to misconduct which was serious."

141. In my judgment, these paragraphs are problematic. The MPT appears to be saying that discussions about fertility with Patient C should have taken place at the initial consultation which took place on 9th November, and that anything later would have been too late. The MPT dismisses the exchanges between the Appellant and Patient C's mother on the sole basis that these were too long after the initial consultation and too long before the script was written. On that analysis, the Appellant faces a penny with two tails. Had there been a full explanation of the risks either in November or December, that would also have been too long before the script was written. Had there been a second face-to-face consultation in, say, April 2017 at which the risks were fully discussed, that presumably would have been too long after the initial consultation. Mr Mant's gallant attempts to save this sentence must in my view be rejected. Further, what the MPT singularly failed to do was conduct any analysis into whether the Appellant's admitted failure to mention risks to fertility during the face-to-face consultation on 8th December 2016 (that in my view was the more relevant date) amounted to serious misconduct in the light of the subsequent emails, the Appellant's oral evidence, and all the circumstances of the case.

142. Contrary to Mr Hodivala's submission, I do not think that anything really turns on the point that in the first line of para 121 the MPT referred to a "probable suppression of fertility". The likelihood was expressed to a lesser degree in the findings of fact. Ultimately, however, the degree of risk to fertility is not material. On any view, this was an important and serious risk that should have been discussed.

143. I am driven to conclude that these paragraphs represent something of a muddle and fail to do justice to the Appellant's case.

144. Despite that conclusion, I am not satisfied that it should compel me to allow the appeal. I need to go further. I do so in two respects.

145. First of all, I consider that it is appropriate to read further into the determinations. The decision on impairment was handed down at the same time and in the same document. In contrast with the determination on sanction whose reasons cannot in my judgment be recruited to save earlier determinations, it would be artificial to ignore the decision on impairment. There, the point is made that although the discussion about fertility risks should have taken place at the initial consultation, there was a five month opportunity to remedy the oversight. Although the MPT expressed its surprise that fertility was

overlooked at the initial consultation, given that it is such an important consideration, Mr Mant's submission, which I accept, was that the MPT appear to have moved away from its finding on misconduct, to the extent that it was not sufficient merely to have regard to the initial consultation and nothing else. The frank inconsistency between these two determinations is unfortunate.

146. I have said that the determination on sanction cannot be deployed by the Respondent to support earlier determinations. That in my judgment would involve unacceptable reverse-engineering. However, the extent to which the determination on sanction may be deployed by the Appellant raises a slightly different issue. I will be coming to that at the appropriate time.

147. The MPT's analysis of the history between 8th December 2016 and the end of April 2017 was, as I have already found, deficient. At this point, therefore, I should set out what I make of that history, doing the best I can.

148. The Appellant acknowledged – to herself at least – that she should have discussed fertility with Patient C at the consultation on 8th December. She then did nothing about it for over two months, and permitted the consent forms to be sent out to Patient C and his mother knowing that there was an important gap in the information that she had provided. It was only when composing the letter to Patient C's GP on 26th February that the Appellant emailed Patient C's mother. In my judgment, it was not good practice simply to enquire, "is this something you have discussed and have full knowledge of or is this something we need to explore a bit further?" This was something that needed to be addressed proactively and not in a manner which may have led to the asking of no questions at all by the mother.

149. The inferences to be drawn from the mother's emails are not altogether clear, at least in the following respect. Patient C's mother did not ask for any clarification relating to the risks to fertility consequent upon proceeding to stage 2. She may have fully understood that the taking of a testosterone would be bound to impact on fertility. On the other hand, her concerns about fertility and puberty blockers may have betrayed a fundamental misunderstanding of what is involved, and the Appellant told her administrative assistant that there was some confusion. Even so, the mother was sent what I have called the wrong form, she was told to read it, and there the relevant risks were explained.

150. It is clear from these emails that Patient C had had some discussion about fertility with his mother. Apparently, he did not wish to have children. How much information was given by mother to child is unclear. How much Patient C understood, or could process, was also unclear but in my opinion that raises a different concern.

151. It is not clear whether the Appellant would have instructed her administrative assistant to provide the explanation she did about the risks of testosterone to fertility had Patient C's mother not written the emails she had. The fact that the Appellant felt that the mother may have been confused is a point that cuts both ways. In the Appellant's favour, she wanted to clarify matters. In my judgment, the email sent by the administrative assistant was important. It did explain the nature of the risks in clear and categorical terms, and although it did not refer to any pathway I believe that there is a high chance that the mother well understood this. The premise on which the email was written, and on which the "wrong" consent form was sent, was of there being a pathway.

152. The Appellant said in evidence that she was satisfied that Patient C's mother was passing on information to him (§53 above). That answer may have been wishful-thinking (as Mr Mant submitted, using his own choice of words); it may even have been untrue (inasmuch as the Appellant gave no thought to this at the time). Although the Appellant did meet Patient C and could judge him for herself, there was a paucity of evidence from her about that. Furthermore, the MPT made no relevant findings about any of this. Additionally, I consider that there is force in Mr Hodivala's submission that there would and should be a reasonable expectation in the majority of cases such as this of further explanation being given by the parent to the child. That would be so even in a situation where an explanation was given by the doctor to the child face-to-face. The MPT accepted the force of this consideration in its sanction determination. It also went to the issue of severity of misconduct, although it is unclear whether the Appellant's then counsel advanced that argument at an earlier stage. I assume that he did, because it is such an obvious point.

153. I have already found that there should have been a discussion about fertility risks with Patient C directly. However, that finding is not the end of the case, and Mr Mant conceded as much by accepting that consideration would still have to be given to whether the omission to have such a discussion amounted to a lack of good clinical care. The same observation applies to the assessment of "serious misconduct". In my judgment, for the reasons I have given any consideration the MPT gave to that question was inadequate.

154. Mr Mant submitted that it was incumbent on the Appellant to prove that the actions she took amounted to good clinical practice, given that she was effectively conceding that no discussion of the risks took place with Patient C directly. Implicit in that submission is the contention that the Appellant should have called Patient C's mother (there was a witness statement from her, but it did not cover the matters I have been addressing). I reject that submission. The burden of proof resided throughout on the Respondent, and at no point did it notionally shift to the Appellant. Insofar as there may have been an evidential burden, it was discharged by adducing the emails.

155. One factor that has caused me concern is that the thrust of the Appellant's evidence before the MPT was that she did not agree with Dr Kierans that a discussion about risks to fertility had to take place at the outset. She justified her failure to discuss fertility on 8th December on the basis that the risks did not have to be explained then, or indeed before the puberty blockers were administered. This was an ongoing discourse. Appellant was therefore saying that Dr Kierans' evidence was wrong. However, Dr Kierans' evidence was right, and that calls into question the quality of care that the Appellant was administering. Moreover, the only reasonable inference to be drawn from the "we forgot" file note was that a discussion about fertility should have taken place at the consultation. Given that it did not, the omission had to be rectified before this treatment commenced. Frankly, the Appellant's attempt in her oral evidence to explain away the file note was ill-judged and did her no favours. It was redolent to me of *ex post facto* justification.

156. To be clear, I am not to be interpreted as saying that there was only one opportunity to advise on the risks to fertility, and that was lost on 8th December 2016. I do not doubt that even the best doctors are occasionally guilty of oversight. Accordingly, I am not quite as surprised as was the MPT by the Appellant's omission on this occasion. However, I am to be interpreted as saying two things. First, the oversight having

occurred and then having been acknowledged, it ought to have been rectified before the end of April 2017. Secondly, that the Appellant's attempts before the MPT to justify her omission were unwise.

157. Drawing all these strands together, my overall conclusion is as follows. The MPT's analysis of the issue of serious misconduct was wrong. The MPT's thinking was confused, clearly wrong in places, and it omitted reference to important evidence. Having conducted my own analysis of the relevant material, I am entirely unable to conclude that this appeal should be dismissed because the Appellant was guilty of serious misconduct. Although I have concerns about certain aspects of the Appellant's practice in relation to Patient C including a failure to have a face-to-face consultation on the issue of fertility, it is far from clear to me that what did take place should be strongly criticised. In addition, it would be clearly unfair and unprincipled to uphold the MPT's determination on the basis of rather different reasoning which has not been fully addressed in expert evidence and tested by cross-examination of the Appellant.

158. In this regard, I have not lost sight of Dr Kierans' evidence that the value of having a direct discussion with the patient is that it enables capacity better to be assessed. Clearly, the Appellant was not able to judge for herself whether Patient C did understand the risks to fertility. The Appellant's robust evidence to the MPT that she was fully satisfied that Patient C had capacity was predicated on an incomplete premise. Even so, this particular issue appears not to have been raised with the Appellant in cross-examination (the questioning was in more general terms), and – as I have said – the Head of Charge relating to informed consent was not found proved.

159. Looking at this now from the other angle, I was urged by Mr Hodivala to allow the appeal on the basis I should safely conclude that the Appellant's practice in relation to Patient C should not be criticised, alternatively was not sufficiently short of amounting to good clinical care as to constitute serious misconduct. In my judgment, she may just about have done enough in the emails to explain the fertility risks to Patient C's mother, and it is certainly a reasonable conclusion that the Appellant did believe that information given to this parent would be transmitted and explained to the child.

160. However, I fall short of coming to the bold conclusion I have mentioned. Even continuing to acknowledge that the burden of proof rests on the Respondent to be discharged on the balance of probabilities, this remains a complex case where the evidence does not all point one way. In particular, there are lacunae in the expert evidence which are not the Respondent's fault. Dr Kierans in particular was not asked about the February emails, and in those circumstances I cannot have sufficient confidence that they went far enough. In addition, I repeat what I have said under §158 above and my other concerns about the Appellant's practice in relation to Patient C.

161. Section 40(7) and (7A) of the Medical Act 1983 provides:

> "(7) On an appeal under this section from a Medical Practitioners Tribunal, the court may —
>
> (a) dismiss the appeal;
>
> (b) allow the appeal and quash the direction or variation appealed against;

> (c) substitute for the direction or variation appealed against any other direction or variation which could have been given or made by Medical Practitioners Tribunal; or
>
> (d) remit the case to the MPTS for them to arrange for a Medical Practitioners Tribunal to dispose of the case in accordance with the directions of the court,
>
> and may make such order as to costs (or, in Scotland, expenses) as it thinks fit.
>
> (7A) Where a case is referred under subsection (7)(d) to the MPTS, the MPTS must arrange for the case to be disposed of by a Medical Practitioners Tribunal in accordance with the directions of the court."

162. I have already decided that this appeal should not be dismissed. This is not a case which engages section 40(7)(c). It follows that my options lie either sub-paragraph (b) or sub-paragraph (d). However, I have already decided that I should not be allowing the appeal on the footing that I am able to decide for myself whether the Appellant's practice amounted to serious misconduct in connection with para 5(d)(iii). If sub-paragraph (b) were the correct course, it would be so for a different reason.

163. After the hearing I invited submissions from the parties on the way forward. I provided a draft of this judgment to them so that they could see my provisional conclusions up to and including this point.

164. Mr Mant submitted that I should remit this case under sub-paragraph (d) to determine the issues which are outstanding, including whether the Appellant's failure to discuss fertility risks with Patient C amounted in all these circumstances to a want of good clinical care. Mr Mant accepted that the Court has a discretion in these circumstances not to remit, but he argued that this should be exercised only exceptionally and in line with the policies and objects of the statutory scheme. Given the Appellant's apparent lack of insight, there was a real risk of repetition. The underlying public safety concerns required the exercise of power under sub-paragraph (d).

165. Mr Hodivala submitted that this is an exceptional case and that a remittal under sub-paragraph (d) would be oppressive and disproportionate. He contended that sections 1(1A) and (1B) of the Medical Act 1983, including public protection, applied to the Respondent's functions and not to the role and functions of the Court on a statutory appeal. He submitted that the problems with this case arose, at least in part, because there was a lack of focus in the manner in which the Respondent advanced its case on para 5(d)(iii), and this led to a failure to cross-examine the Appellant on many of the issues I have identified. He further submitted that the concerns set out in this judgment about the Appellant's clinical practice are not serious, and this – at its highest - was effectively a one-off lapse. Mr Hodivala also made the point that the public protection concerns were not sufficiently cogent to justify putting the Appellant through further disciplinary proceedings.

166. Both counsel made submissions as to the difference, if any, between interim suspension orders and orders made after a full hearing.

167. I have not found this issue easy to resolve. I reject Mr Hodivala's submission that sections 1(1A) and (1B) of the Medical Act 1983 do not inform the Court's exercise of its discretion under section 40. In my view, these provisions clearly do apply, particularly so in circumstances where the Court is being invited by the registrant not to remit the case to the expert tribunal. I also accept Mr Mant's submission that only limited weight may be given to the fact that the Appellant has been subject to an interim suspension order for a considerable period of time: such orders are made for different reasons and under different provisions. In my view, paragraph 85 of *Abdul-Razzak v General Pharmaceutical Council* [2016] EWHC 1204 and paragraph 35 of *Kamberova v NMC* [2016] EWHC 2955 are readily reconcilable. Additionally, that the MPT in the present case made an order under section 38 of the Medical Act 1983 is a factor militating against the Appellant's argument rather than in favour of it. The better submission may be that the MPT's analysis of this case was flawed at various stages, and so what it decided to do under section 38 is of little consequence.

168. Furthermore, this is not a paradigm case triggering sub-paragraph (b). That provision usually applies where the Court considers that the appeal should be allowed because it can determine the relevant issue for itself, whether it be the facts, misconduct or impairment. I repeat that I am unable to do so. There is agreement between the parties that what is required here is an exceptional case.

169. Having considered the issue very carefully, ultimately I am satisfied that it would be unjust and wrong to remit this case to the MPTS for further consideration by the MPT in the light of this judgment. My reasons are as follows.

170. First, there is force in Mr Hodivala's submission that part of the difficulty arose owing to a lack of focus in the Respondent's case in relation to para 5(d)(iii). Had the Appellant been cross-examined on all the matters which I have covered, and had the MPT still made the same errors, it might well have been easier for me to reach my own conclusions.

171. Secondly, the Appellant is not to be blamed for the quality of the MPT's determinations and its failure to wrestle with these admittedly complex issues in the correct manner.

172. Thirdly, were the matter to go back to the MPT all issues would have to be redetermined. Mr Mant's submissions accept that. In particular, there would have to be further oral evidence from the Appellant and further expert evidence dealing with the emails and the consent forms. The preparation as well as the hearing itself would be far from short, and it would take some time to come on. A further hearing would also give the Respondent the opportunity to cross-examine the Appellant in a different way and on matters which should have been addressed first time round.

173. Fourthly, this is far from being the most serious case. One way or the other, the Appellant would have a reasonably good chance of not being suspended at all.

174. As against these factors should be counterbalanced the Appellant's then counsel's failure to cross-examine any witness on the various emails. Further, I do not downplay the importance of review hearings even in cases with short periods of suspension.

175. Overall, I do consider that it would be disproportionate, if not oppressive, to put the Appellant through further significant delays and another hearing.

176. Finally, I should state that although it has not proven necessary to address the Appellant's further grounds of appeal, I would not have allowed the appeal on the issues of impairment and sanction. Put shortly, assuming that errors had not been made at an earlier stage, the MPT reached reasonable and fair decisions based on its evaluation of the Appellant's degree of insight, or lack of it.

DISPOSAL

177. This appeal must be allowed on the ground that the MPT's determination on the issue of misconduct was wrong. I make an order under section 40(7)(b) of the Medical Act 1983. The Appellant's case ends here and will not be remitted to the MPTS for redetermination.

POSTSCRIPT

178. The sole focus of this appeal has been the quality of the Appellant's clinical practice in relation to one patient, Patient C. This appeal does not raise any wider issues about the wisdom or otherwise of administering puberty blockers to the younger age group who wish to undergo interventions for gender reassignment with full parental agreement.

ANNEX

CONSENT FORMS

PUBERTY BLOCKERS FOR UNDER 16 FTM WITH GENDER DYSPHORIA

(This is the form which Patient C and his mother signed. It was not the form which the MPT considered)

I am receiving treatment for gender dysphoria. The cause of gender dysphoria is not known, but it is thought to be partly due to prenatal open (before birth) hormones affecting early development of my brain pathways. I understand that the effect of this on me means that, even though I think of myself completely as male, I am genetically, biologically and physically female. I want to receive treatment that will help me change my body to that of a male so that it will match my sense of myself (my gender identity) as a male.

I understand that part of the treatment relies on having a good support network and that counselling is always a possibility should it be deemed necessary.

If it is felt the treatment is inappropriate or should be halted, then that remains at the discretion of the supervising transgender team.

I understand that it is normal practice to start treatment with GnRH analogues (puberty blockers) in the first instance, with testosterone not being started until an agreed age and only after all parties have considered all options and are in agreement. The puberty blockers will be administered by injection. Under exceptional circumstances where severe dysphoria is being experienced, testosterone will be started before the age of 16 in addition to the puberty blockers, but this will be at the discretion of the supervising transgender team.

I understand that in order to monitor my progress, that regular blood tests may be requested. These will be organised through my GP or if that is not possible, by the supervising transgender team.

I know this treatment will not change my genetic sex (chromosomes), and it will not change my internal reproductive structures (ovaries, uterus, and vagina).

I agree to take puberty blockers as described and to tell my doctor if I am not happy with the treatment or I am experiencing any problems. I understand that the right dose or type of medication prescribed for me may not be the same as for someone else. I understand that physical examinations and blood tests may [WORD MISSING] needed on a regular basis to check for negative side effects of the treatment. I understand that being honest with my doctor about what else I am taking will help prevent medical complications that could be life-threatening. I have been informed that I will continue to get medical care no matter what information I share. I understand that some medical conditions make it dangerous to take testosterone in the future. I agree that if my doctor suspects I may have one of these conditions, I will be checked for it before the decision to start testosterone in the future is made.

My signature below confirms that:

- My doctor has talked with me about the benefits and risks of puberty blockers, the possible or likely consequences of hormone therapy, and potential alternative treatment options.

● I understand the risks that may be involved.

● I understand that this form covers known effects and risks and that there may be long-term effects or risks that are not yet known.

● I have had sufficient opportunity to discuss treatment options with my doctor. All of my questions have been answered to my satisfaction.

● I believe I have adequate knowledge on which to base informed consent to the provision of puberty blockers and testosterone therapy.

Based on this, I wish to begin taking these medications,

_____

Parent #1 Signature Date

Parent#2 Signature Date

I understand that my parents have given permission for me to begin taking testosterone. I have had this consent form explained to me and agree to the testosterone treatment.

_____

Patient's Signature Date

PUBERTY BLOCKERS AND TESTOSTERONE THERAPY FOR UNDER 16 FTM WITH GENDER DYSPHORIA

(This was the form the MPT considered. It was not the form that was in fact signed)

I am receiving treatment for gender dysphoria. The cause of gender dysphoria is not known, but it is thought to be partly due to prenatal (before birth) hormones affecting early development of my brain pathways. I understand that the effect of this on me means that, even though I think of myself completely as male, I am genetically, biologically and physically female. I want to receive treatment that will help me change my body to that of a male so that it will match my sense of myself (my gender identity) as a male.

I understand that part of the treatment relies on full psychological counselling and assessment with a trained transgender counsellor and in addition to the initial assessment, future regular counselling sessions will also be necessary.

If it is felt that treatment is inappropriate or should be halted, then that remains at the discretion of the supervising transgender team.

I understand that is normal practice to start treatment with GnRH analogues (puberty blockers) in the first instance, with testosterone not being started until the age of 16. The puberty blockers will be administered by injection. Under exceptional circumstances where severe dysphoria is being experienced, testosterone will be started before the age of 16 in addition to the puberty blockers, but this will be at the discretion of the supervising transgender team.

I understand that in order to monitor my progress, that regular blood tests may be requested. These will be organised through my GP or if that is not possible, by the supervising transgender team.

I understand that I may now begin taking the male hormone testosterone, in a dose that would be proper for other males my age. I understand that testosterone will cause my body to become more male in appearance, and it will reduce my female hormones. This will probably mean that I will not menstruate (have “periods”), and that I will not be fertile (able to get pregnant) for the duration of the treatment. I know this treatment will not change my genetic sex (chromosomes), and it will not change my internal reproductive structures (ovaries, uterus, and vagina).

I understand that, although testosterone is a common treatment for adults with gender dysphoria, using this treatment in young adolescents is a newer development, and the long-term effects are not fully known. It has been explained to me that doctors are prescribing testosterone because they believe that I will continue towards full physical transition to a male, perhaps including eventual surgery to remove my inner female reproductive structures (ovaries and uterus). There is another kind of surgery, to create male genitalia (penis and scrotum) that is also a separate decision. However, taking testosterone now does not guarantee that I will eventually want, need, or have these surgeries. Gender-reassignment surgery has to be talked about in detail when I am further along in my transition, and final decisions can only be made after I have been living continuously in the gender role that is congruent with my gender identity as a male for a period of time.

There are also possible long-term considerations and risks of testosterone use in genetic females, as follows:

1. The masculinizing effects of testosterone can take several months or longer to become noticeable, the rate and degree of change can't be predicted, and changes may not be complete for 2-5 years after starting testosterone.

2. The following changes will likely be permanent, even if testosterone is discontinued:

- Lower voice pitch (i.e. voice becoming deeper)
- Increased growth of hair, with thicker/coarser hairs, on arms, legs, chest, back, and abdomen
- Gradual growth of moustache/beard hair
- Hair loss at the temples and crown of the head, with the possibility of becoming completely bald
- Genital changes may or may not be permanent if testosterone is stopped; these include clitoral growth (typically 1-3cm) and vaginal dryness

3. The following changes are usually not permanent (that is, they will likely reverse if testosterone is discontinued):

- Acne, which may be severe and can cause permanent scarring if not treated
- Fat may redistribute to a more masculine pattern (decreased on buttocks/hips/thighs, increased in abdomen – changing from "pear shape" to "apple shape")
- Increased muscle mass and upper body strength
- Increased libido (sex drive)
- Menstrual periods typically stop within 1-6 months of starting testosterone

4. It is not known what the effects of testosterone are on fertility. Even if you stop taking testosterone, you may or may not be able to get pregnant in the future. Even after testosterone stops your menstrual periods, it may be still be possible for you to get pregnant, and you must be aware of birth control options (if applicable). You may not take testosterone if you are pregnant. You still need to protect yourself from sexually transmitted infections.

5. There are some aspects of your body that will not be changed by testosterone:

- Breasts may appear slightly smaller due to fat loss, but will not substantially shrink
- Although voice pitch will likely drop, other aspects of speech will not become more masculine

6. Taking testosterone can cause changes that increase the risk of heart disease; including:

- Decreasing good cholesterol (HDL) and increasing bad cholesterol (LDL)

- Increasing blood pressure
- Increasing deposits of fat around the internal organs

7. The risks of heart disease are greater if people in the family have had heart disease, if you are overweight, or if you smoke. The doctor can provide you with advice about options to stop smoking.

8. Heart health check-ups, including monitoring of weight and cholesterol levels, should be done periodically as long as you are taking testosterone.

9. Taking testosterone can damage the liver, possibly leading to liver disease. You should be monitored for possible liver damage as long as you are taking testosterone.

10. Taking testosterone can increase the red blood cells and haemoglobin, and while the increase is usually only to a normal male range (which does not pose health risks), a high increase can cause potentially life-threatening problems such as stroke and heart attack. Your blood should be monitored periodically while you are taking testosterone.

11. Taking testosterone can increase the risk for diabetes by decreasing the body's response to insulin, causing weight gain, and increasing deposits if fat around the internal organs. Your fasting blood glucose should be monitored periodically while you are taking testosterone.

12. Testosterone can be converted to oestrogen by various tissues in my body, and it is not known with certainty whether or not this increases the risks of ovarian, breast, cervical or uterine cancer.

13. Taking testosterone can lead to the cervix and the walls of the vagina becoming more fragile, and this can lead to tears or abrasions that increase the risk of sexually transmitted infections (including HIV) during vaginal sex – no matter the gender of the partner. Frank discussion with your doctor about your sexual practices can help determine how best to prevent and monitor for sexually transmitted infections.

14. Taking testosterone can cause headaches or migraines. If you are frequently having headaches or migraines, or the pain is unusually severe, it is recommended that you talk with your doctor.

15. Taking testosterone can cause emotional changes, including increased irritability, frustration, and anger. Your doctor can assist you in finding resources to explore and cope with these changes.

16. Taking testosterone will result in changes that will be noticeable by other people, and some transgender people in similar circumstances have experienced harassment, discrimination, and violence, while others have lost support of loved ones. Your doctor can assist you in finding advocacy and support resources.

17. It is strongly advised not to take more testosterone than prescribed, as this increases health risks. Taking more medication than prescribed will not make masculinization happen more quickly or increase the degree of change. Extra testosterone can be converted to oestrogen, which may slow or stop masculinization.

18. Since biological men make testosterone their whole lives, testosterone therapy for gender dysphoria is generally continued lifelong.

19. The medical effects and safety of testosterone are not fully understood, and there may be long-term risks not yet known. I agree to take puberty blockers and testosterone as prescribed and to tell my doctor if I am not happy with the treatment or am experiencing any problems. I understand that the right dose or type of medication prescribed for me may not be the same as for someone else. I understand that physical examinations and blood tests may be needed on a regular basis to check for negative side effects of testosterone. I understand that testosterone can interact with other medications (including other sources of hormones), dietary supplements, herbs, alcohol and street drugs. I understand that being honest with my doctor about what else I am taking will help prevent medical complications that could be life-threatening. I have been informed that I will continue to get medical care no matter what information I share. I understand that some medical conditions make it dangerous to take testosterone. I agree that if my doctor suspects I may have one of these conditions, I will be checked for it before the decision to start or continue testosterone is made. I understand that my doctor may suggest I reduce or stop taking testosterone if there are severe side effects or health risks that can't be controlled.

My signature below confirms that:

- My doctor has talked with me about the benefits and risks of puberty blockers and testosterone, the possible or likely consequences of hormone therapy, and potential alternative treatment options.

- I understand the risks that may be involved.

- I understand that this form covers known effects and risks and that there may be long-term effects or risks that are not yet known.

- I have had sufficient opportunity to discuss treatment options with my doctor. All of my questions have been answered to my satisfaction.

- I believe I have adequate knowledge on which to base informed consent to the provision of puberty blockers and testosterone therapy.

Based on this, I wish to begin taking these medications,

_____

Parent #1 Signature Date

Parent#2 Signature Date

I understand that my parents have given permission for me to begin taking testosterone. I have had this consent form explained to me and agree to the testosterone treatment.

_____

Patient's Signature Date

FINDINGS OF FACT

Paragraph 5

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

d. Advised Patient C as to the risks of GnRHa before commencing treatment without

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

584. The Tribunal was mindful that, according to WPATHSOC7, gender dysphoria is to be managed in stages. Stage 1 is suppression of puberty, using, for example, GnRHa; stage 2 is the induction of trans-puberty by administration of GAH (testosterone in the case of FTM transition). Stage 1 interventions are regarded as reversible, whereas the reversibility of stage 2 interventions is less certain and in some cases may be irreversible. The Tribunal also bore in mind Professor Butler's evidence that approximately 95% of persons accepting stage 1 interventions go on to request stage 2 treatment.

585. The Tribunal had regard to the Informed Consent form which was completed on 9 February 2017. The Tribunal noted that the consent form refers to both 'puberty blockers' and 'testosterone'. However, the only mention in respect of fertility risks is in the context of testosterone treatment. This reads:

> "This will probably mean that I will not menstruate (have "periods"), and that I will not be fertile (able to get pregnant) for the duration of the treatment."

586. The Tribunal was of the view that whilst form does touch upon fertility, it does not spell out, in any detail, the seriousness of or the profound impact of the treatment in relation to fertility. In particular, it does not explain that the likelihood is that a patient who commences treatment with GnRHa will go on to receive GAH treatment and that therefore, embarking on GnRHa treatment is likely to have a profound effect on his fertility.

587. The Tribunal also had regard to email correspondence between Dr Webberley's clinic and Patient C's mother on 26 February 2017. These state as follows:

> " Email of 26 February 2017 (timed at 4:12 pm)
>
> 'Hi [Patient C's mother] apologies for the delay. One of the things we haven't discussed is fertility, is this something you have discussed and have full knowledge of or is this something we need to explore a bit further? Dr Webberley'
>
> Email of 26 February 2017 (timed at 4:31 pm)
>
> 'Hi Helen
>
> It is something we have discussed with he is adamant he doesnt want children but I'm not sure thats something an 11 yr old can be definite about? Blockers, though, as we understood, are not supposed to interfere with fertility are they?'

> Email of 26 February 2017 (timed at 5:06 pm)
>
> 'Sorry Helen, re my reply below…just be clear, obviously we understand fertility is affected whilst taking the blockers…but it is our understanding that fertiltity [sic] would return if blockers are stopped…is that correct? At that point, he would have to experience a return to a female puberty should he decided he wants eggs harvested and stored? We are aware that harvesting eggs is not an easy process and storage costs would be incurred. Is there any other information we might need?'

588. Whilst the Tribunal accepts this demonstrates that some discussion did take place between Dr Webberley and Patient C's mother, it is not satisfied that this is sufficient in relation to the risks and consequences upon fertility of what is life changing treatment. Further, the Tribunal has not been provided with any contemporaneous notes or objective evidence to be satisfied Dr Webberley discussed the risks to Patient C's fertility.

589. The Tribunal therefore found paragraph 5(d)(iii) of the Allegation proved.

MISCONDUCT

116. The Tribunal was of the view that, for the GMC, Dr Kierans' assessment of the obligation was the most helpful. She said in evidence:

> "If it [fertility] was not discussed directly with the young person in my opinion that would be a failure of informed consent. Although we're aware that the blockers have a reversible effect on fertility it's something that we consider right from the beginning of conversations about blockers and for lots of reasons. So firstly it gives us a chance to think about capacity – does the young person understand the impact of the blockers and the impact of potentially later on other cross-sex hormones? So the young person would be able to demonstrate their understanding and then we're able to fill in any gaps or explain.
>
> Also if a young person does want to take steps to preserve fertility that is quite a lengthy process and it needs to be commenced. Within KOI most of our young people are only on blockers for around a year so if they do want to preserve fertility, they need to get the referral commenced as quickly as possible so that they can go through that process and it doesn't cause any delays to them being able to start cross-sex hormones when their period of time on blockers is completed. So it's something that needs to be discussed with young people prior to beginning treatment so that you can be sure that they have considered the impact of this treatment pathway that they're starting because even though the blockers have a reversible effect it is the beginning of a pathway that does lead to cross-sex hormones in most cases which do have an irreversible effect on fertility so it's important that the young person is very clear about that and that you've discussed it with them."

117. However, Dr Shumer identified the dilemma facing a doctor in Dr Webberley's position. He said, in answer to the following question:

> "'Q Where an issue has been flagged up in the notes that the issue of fertility had not been addressed with the patient and needed to be addressed prior to the commencement of blockers, is that something that should be addressed before blockers are prescribed with the patient?
>
> A I think that's a very interesting question because the use of GnRH analogues by themselves do not impact fertility so that, you know, if someone uses GnRH analogues to pause puberty and then it's discovered that their male puberty is the right puberty for them, they come off GnRH analogues and progress through puberty and have, we would imagine, normal fertility. Just like we use GnRH analogues for kids with precocious puberty and don't anticipate fertility compromise.

> I think a challenge of talking about fertility with someone of this age group is that they're not equipped to understand fertility very well and that's another reason why GnRH analogues are used to allow more time and maturity for a patient to be equipped to discuss issues of fertility that can be compromise with use of cross-sex hormones. But I oftentimes bring up the topic of fertility only to say that when embarking down a pathway towards potential cross-sex hormones and at that point a discussion about fertility will be important, but I'm not sure that fertility is a topic well received by patients in the age group that are considering blockers and so it is one of the more challenging sort of questions to know how to navigate that."

118. Dr Webberley stated in her reflective statement:

> "I had not adequately discussed fertility preservation with Patient C and his mother at our consultation and went back to clarify further in writing."

119. She continued:

> "The discussion around fertility is a continual one over many years, with many trans adolescents being much more able to enter into these discussions once the acute fear of pubertal development has subsided because of blocker treatment, and they can take more time to consider the next stages."

120. The Tribunal was mindful of the point that the moment to which the charge relates was not the last opportunity for Dr Webberley to discuss the risks to fertility with Patient C, although it did recognise the point that the vast majority of patients who are treated with GnRHa go on to take gender affirming hormones. It also noted that Dr Webberley was aware of her omission and sought to correct it when she wrote to Patient C's mother on 26 February 2017, but this was long after the consultation which took place on 9 November 2016 and significantly before Dr Webberley wrote the prescription on 29th April 2017.

121. The Tribunal considered that the probable permanent suppression of fertility was a matter which ought to have been raised by Dr Webberley with Patient C at the time of the consultation. It recognised that puberty suppression is reversible, and that discussing fertility with a young person is difficult, and that it takes time for a person to think through such weighty matters. However, it is in evidence that most patients opting for puberty suppression will later request GAH. Therefore, the initial consultation was a key juncture; Dr Webberley should have started the ball rolling in respect of fertility so that Patient C could have time to absorb the information and reflect on it.

122. In the circumstances, the Tribunal find that Dr Webberley's omission to discuss the risks to Patient C's fertility before commencing treatment amounted to misconduct which was serious.

IMPAIRMENT

161. The Tribunal noted that Dr Webberley does acknowledge her error in not discussing fertility with Patient C, and that she sought to address that by engaging with Patient C's mother in writing about the issue. It was, however, concerned that, in her reflective statement and in her evidence, she did not acknowledge that it behoved her to discuss this directly with Patient C, albeit in the sense of "starting the ball rolling", when she realised her error, and that this was the case notwithstanding that she had until late April 2017 (when she wrote the prescription) to do so, a period of five months from the date of the consultation. Indeed she does not say that it would now be her practice to discuss fertility even in this sense with all new patients. Moreover, the Tribunal was surprised by the fact that she omitted to discuss fertility with Patient C in the consultation as it is such an important aspect of transgender medicine.

162. The Tribunal noted Dr Kierans' observations, quoted in its determination on facts, that there was a practical reason for discussing fertility as early as possible, namely preservation of fertility.

163. The Tribunal accepted that Dr Webberley recognises, particularly after the case of *Bell v. Tavistock*, that there will be cases when a transgender patient will regret a decision to change her gender, something which highlights the significance of the discussion on fertility.

164. The Tribunal accepted that Dr Webberley has an interest in the issue of fertility, particularly in relation to the issue of gamete storage, a matter which was the subject of published research by her in 2020 (in which she was the senior author) and of a conference which she attended in January 2020.

165. Nevertheless, the Tribunal did not consider that Dr Webberley has developed sufficient understanding as to the significance of how she failed Patient C in regard to discussing fertility, and as to how she can be sure that this will not be repeated. It therefore determined that her fitness to practise is impaired by reason of her misconduct in failing to discuss the risks to Patient C's fertility with him on public protection grounds.

166. The Tribunal is fully aware that Patient C was being prescribed GnRHa - regarded as completely reversible - by Dr Webberley. It noted that the Endocrine Society Guideline recommends:

> "We recommend that all transsexual individuals be informed and counseled regarding options for fertility prior to initiation of puberty suppression in adolescents and prior to treatment with sex hormones of the desired sex in both adolescents and adults."

167. However, the Guideline does not disclose the strength of the evidence on which that recommendation is based. Further the Tribunal noted that, in the section concerning the responsibilities of hormone prescribing physicians, WPATHSOC7 recommends a discussion concerning risks as follows:

> "Discuss with patients the expected effects of feminizing/masculinizing medications and the possible adverse health effects. These effects can include a reduction in fertility

> (Feldman & Safer, 2009; Hembree et al., 2009). Therefore, reproductive options should be discussed with patients before starting hormone therapy (see section IX).'

168. There is no corresponding recommendation in respect of GnRHa prescriptions. In these circumstances, the Tribunal does not consider that it is appropriate to find impairment of fitness to practise on public interest grounds alone.

SANCTION

30. The relevant finding of the Tribunal in respect of impairment is paragraph 165 which reads:

'165. Nevertheless, the Tribunal did not consider that Dr Webberley has developed sufficient understanding as to the significance of how she failed Patient C in regard to discussing fertility, and as to how she can be sure that this will not be repeated. It therefore determined that her fitness to practise is impaired by reason of her misconduct in failing to discuss the risks to Patient C's fertility with him on public protection grounds.'

31. Of course the Tribunal's finding relates to the precise language of the paragraph of the Allegation. That identifies that the discussion should have taken place before treatment commenced. There are a number of points which, in the Tribunal's view, add context to the failure which the Tribunal found proved, as follows:

• Issues relating to the treatment of gender dysphoria, including the risks to fertility, are on-going and warrant continuing discussion;
• The Tribunal was concerned that Dr Webberley did not "start the ball rolling" by engaging in discussion with Patient C about the risks to his fertility before commencing treatment. That contemplates that the ball will continue to roll after commencement of treatment;
• Fertility was mentioned at the consultation but there was no ensuing discussion;
• Dr Webberley recognised her omission herself contemporaneously, without stimulus from a third party. Indeed, she disclosed it in her letter to Patient C's GP;
• Dr Webberley recognised this as an error in her reflective statement;
• Dr Webberley sought to correct that error contemporaneously by engaging extensively with Patient C's mother in writing;
• Patient C was aged 10 years and 8 months when she consulted with him on the telephone and 10 years and 9 months when she was saw him face -to-face in December 2016. A discussion on the telephone and/or face-to-face with Patient C when he was that age would certainly have involved significant input from Patient C's mother;
• Dr Webberley was reassured in her correspondence with Patient C's mother.

32. Notwithstanding these points, which the Tribunal consider diminish the seriousness of the finding of impairment, the Tribunal found serious misconduct and that Dr Webberley's fitness to practise is impaired by her lack of insight. In the Tribunal's view that finding means that it would not be appropriate to close this case with no action. Dr Webberley needs to demonstrate to a Medical Practitioner's Tribunal that she has developed the necessary insight and remediation to enable it to conclude that there is no risk of repetition.

33. The Tribunal concluded that the misconduct found is remediable. The Tribunal is satisfied that Dr Webberley should be allowed an opportunity to demonstrate whether she has achieved the necessary insight and that she has remediated her shortcomings. That will enable her to return to unrestricted practise. The Tribunal recognises that it should only impose the least restrictive sanction consistent with its duty, in this instance, to protect the public. However, it does not consider that an order of conditions is an appropriate sanction in the circumstances of this case. It finds that the appropriate sanction for this aspect of the Tribunal's finding of impairment is a period of suspension. The Tribunal's final decision on sanction is, of course, subject to its determination in respect of the other aspects of impairment found in this case.

…

44. The Tribunal, therefore, finds that a suspension order on Dr Webberley's registration to address the impairment found on public protection grounds arising from paragraph 5(d)(iii) of the Allegation is the appropriate sanction in this case.

45. In determining the length of the suspension, the Tribunal considered whether it should take into account the interim orders imposed upon Dr Webberley's registration prior to these proceedings. It concluded that it should not do so. The period of suspension which the Tribunal considers it should impose is that period which allows Dr Webberley the opportunity to demonstrate her level of insight into this aspect of the Tribunal's finding of impairment. The Tribunal has determined therefore to suspend Dr Webberley's registration for a period of two months. The Tribunal considered that this period will allow Dr Webberley sufficient time to demonstrate whether she has the necessary insight into the concerns identified by this Tribunal and that she has remediated her shortcomings. It is also the shortest practical period to make arrangements for a review hearing to take place.