Neutral Citation Number: **[2023] EWHC 734 (Admin))**

Case No: CO/2811/2022

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 31/03/2023

Before:

MR JUSTICE JAY

- -

Between:

DR HELEN WEBBERLEY **Appellant**

- and –

GENERAL MEDICAL COUNCIL **Respondent**

- -
- -

Jamas Hodivala KC (instructed by **Gunner Cooke LLP**) for the **Appellant**
Peter Mant (instructed by **GMC**) for the **Respondent**

Hearing date: 14th March 2023

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Approved Judgment

This judgment was handed down remotely at 10:30am on 31st March 2023 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

MR JUSTICE JAY:

INTRODUCTION

1. Dr Helen Webberley ("the Appellant") is a registered General Practitioner with a special interest in sexual and transgender medicine. She has operated a website called "GenderGP". Her practice was investigated by the General Medical Council ("the Respondent") and in due course charges were brought in relation to her treatment of three transgender children, Patient A, Patient B and Patient C.

2. There was an 85-day hearing before a Medical Practitioners Tribunal ("MPT") (including deliberation), spread over the course of about one year. Both the Appellant and the Respondent were represented by counsel who are no longer instructed. There were over 20 allegations and sub-allegations, but in the end the only one that mattered was Head of Charge or Allegation paragraph 5(d)(iii) ("para 5(d)(iii)"), which provided, as amended, as follows:

> "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;"

3. Although adverse findings of facts were made against the Appellant on other limbs of the charge, the only one which led to a finding of impairment of fitness to practise and a sanction was para 5(d)(iii). In the result, on 30th June 2022 the Appellant was suspended from practice for a period of two months with a direction that a review hearing take place before the end of the suspension period.

4. The Appellant now appeals under section 40 of the Medical Act 1983, as amended, against the findings of fact, misconduct, impairment and sanction in relation to para 5(d)(iii).

ESSENTIAL FACTUAL BACKGROUND

5. I derive this from the parties' skeleton arguments and the documents in the core bundle.

6. In order to set the scene, I must begin with three points.

7. First, children who are assigned female at birth and who identify as male typically undergo any requested medical intervention in two stages. The first stage involves the administration of a GnRHa (gonadotropin-releasing hormone agonist) or puberty blocker. This relieves the child from the acute distress of puberty and has the practical consequence of giving him time to reflect on his choices. The second stage involves the administration of testosterone which, in the circumstances I am addressing, operates as a gender-affirming or cross-sex hormone to induce the secondary sex characteristics that match their gender identity.

8. Secondly, it was clear on the evidence before the MPT that stage 1 is the beginning of a treatment pathway for the vast majority of children. This is because at least 90% of children (the precise figure may be controversial but does not matter) who take puberty blockers proceed to stage 2. This is a factual reality which does not obviate the need for further discussion between doctor and patient before stage 2 begins, but it potentially has an important impact on the doctor's obligations before stage 1 begins. Speaking in very general terms at this stage, stage 1 is reversible (if the child ceases the puberty blockers and does not take any gender-affirming or cross-sex hormones, he will resume female puberty) whereas stage 2 may well not be, particularly in the context of fertility. In these circumstances, although a child will be infertile whilst on puberty blockers, there are no long-term risks to fertility as a direct consequence of that treatment.

9. Thirdly, it is incumbent on all doctors whose patients wish to undergo this form of treatment to assess whether he (in the case under consideration) is *Gillick* competent to make decisions about his treatment. If a positive assessment of competency were made in any given case (as it was by the Appellant in the present case), the parent cannot "trump" or overbear the child's decision in the event of disagreement between them (see *AB v CD & Tavistock and Portman NHS Foundation Trust and others* [2021] EWHC 741 (Fam), paras 67-68 in particular). But, in the light of the parties' submissions before me the extent to which parental consent remains relevant in the case of a *Gillick* competent child where there is agreement within the family is a key issue which I will need to resolve.

10. Any requirement to obtain the informed consent of the patient creates the obvious practical difficulty that children aged nearly 11 (I am bringing the consideration round to the particular facts of the present case) may well be able to understand very basic aspects of puberty-suppression at stage 1 and gender-transition at stage 2, but will find it harder to grasp the ramifications of these treatments on fertility.

11. The Appellant qualified as a doctor in 1992. In 2016 she resigned from her GP partnership in Wales and began practising in the area of transgender medicine through GenderGP. A GMC investigation against her commenced in December 2016, and during its course she was made subject to various interim orders including conditions and suspension. The MPT hearing began on 26th July 2021 and, as I have said, concluded on 30th June 2022. By that time the Appellant had already been suspended on an interim basis for over two years.

12. It is unnecessary to examine the cases of Patients A and B.

13. Patient C was born in 2006 (I am not giving the date of birth in order to do my utmost to safeguard anonymity) and was assigned female at birth. According to his mother's statement, Patient C identified as male and was diagnosed with gender dysphoria. Before October 2016 Patient C had started puberty and his mother approached the Appellant on 17th October by email, requesting a consultation. There was an initial telephone conversation involving Patient C, his mother and the Appellant on 9th November 2016, and a face-to-face appointment on 8th December. On the same day an appointment also took place with a psychologist, Dr Vickie Pasterski.

14. The Appellant assessed Patient C as *Gillick* competent to make decisions about his treatment. I understand that this assessment was based, at least in part, on Dr Pasterski's

report. Her alleged failure to make an assessment of competency was one of the Heads of Charge, but the MPT accepted the Appellant's evidence on this issue.

15. It is notable that the Appellant wrote what appears to be a file note at 14:28 on 8th December, shortly after the 45-minute consultation with Patient C and his mother. In this she stated:

> "We fully discussed the role of blockers which would prevent further female puberty developing and would give us the chance to decide which puberty would [be] the best one for [Patient C] around the age of 14 or so. We didn't talk about fertility, it got mentioned and then we forgot to talk about it, so that needs to be addressed."

16. A number of matters arise. First, although the Appellant clearly recognised that fertility should be addressed, she did nothing to rectify this omission for a couple of months. Secondly, the file note does not record in terms that gender-affirming hormones were discussed. Indeed, on a literal reading of the file note the discussion was limited to the role of puberty blockers. However, in my view it is a reasonable inference from the document (as borne out by her oral evidence) that the Appellant gave Patient C and his mother at least an overview of the treatment pathway from puberty blockers to testosterone, and the reference to discussing at the age of 14 which puberty would be the best for Patient C only makes sense if he were told how a male fertility might be achieved. Thirdly, I agree with the GMC's interpretation that by writing this file note the Appellant was accepting that her oversight had to be addressed, although I do not draw the further inference that the Appellant was impliedly conceding that this had to be achieved by way of face-to-face consultation with Patient C.

17. On 10th January 2017 Patient C's mother sent an email to GenderGP stating that they would like to proceed with puberty blockers. There was a second appointment with the psychologist on 21st January.

18. On 7th February the clinic manager sent copies of two consent forms to Patient C's mother. She was told by email to "have a really good read of these consent forms". One may see from the attachments to the email that one of the forms related to "FtM" consent, the other to "PB only".

19. Patient C's mother was confused as to which form should be signed. That was understandable. By email sent on 8th February, she "presume[d] that we only sign the one about blockers not the testosterone one?". Patient C's mother was then advised that they should sign just the blockers' one, and that the other was for information only.

20. Unfortunately, the MPT was shown the wrong consent form. Their bundle contained the form for puberty blockers and testosterone treatment. That was the form "for information only". The correct form, which was signed by Patient C and his mother on 9th February and then returned by scanned email to the clinic, was the one for puberty blockers alone.

21. The Annex to this judgment contains both versions of the consent form, the right one and the wrong one. The wrong form, as I am describing it, deals in some detail with the risks to fertility consequent on testosterone treatment, although the MPT was

nonetheless highly critical of it. The MPT could not conduct any analysis of the right form and I will have to do my best with it in all the circumstances.

22. On 26th February at 16:12 the Appellant drafted a letter to Patient C's GP. After setting out the history, the Appellant said this:

> "We didn't talk about fertility, it got mentioned and then we forgot to talk about it, so that needs to be addressed."

This was the first occasion on which the Appellant's oversight, first apprehended by her on 8th December, was picked up.

23. Having reminded herself of the oversight, at the same time the Appellant then sent an email to Patient C's mother, in these terms:

> "Hi [REDACTED] apologies for the delay. One of the things we haven't discussed is Patient C's fertility, is this something you have discussed and have full knowledge of or is this something we need to explore a bit further?"

24. On the same afternoon Patient C's mother emailed the Appellant as follows:

> "It is something we have discussed with Patient C; he is adamant he doesn't want children but I'm not sure that's something an 11 yr old can be definite about? Blockers, though, as we understood, are not supposed to interfere with fertility are they?"

25. 35 minutes later, Patient C's mother sent another email:

> "… 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 female puberty should he decide 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 other information we might need?"

26. At 17:49 the Appellant appears to have sent a note to her administrative assistant containing a slightly different version of the GP's letter she had drafted at 16:12. The note to her secretary stated:

> "Letter to GP with VP report and copy to mum – before you send it can you just check we have done everything Mum has asked as this has got a bit confused."

It appears that the Appellant was asking her administrative assistant to check that Patient C's mother fully understood what the treatment entailed. It also appears that the Appellant believed that the mother had some confusion about this.

27. This second draft of the GP letter contained the following different wording:

> "[Patient C] is aware of the effects that treatment may have on fertility and they understand that [Patient C] is young to be making such decisions. Blockers are reversible so we can resume female puberty or carry out egg retrieval at a later stage if we want to."

28. At 17:50, still on 26th February 2017, the Appellant emailed Patient C's mother in these terms:

> "… It is still possible to have egg retrieval while on blockers, and yes, fertility should return if blockers are stopped. We can revisit this as we go forward. Let me know if you have any queries. I will write to your GP and copy you in."

29. At 22:06 that evening, Patient C's mother emailed the Appellant as follows:

> "Egg retrieval while on blockers? I didn't realise that … I imagine it would be done in a similar way to IVF … stimulating the ovaries to produce follicles, then harvesting. Surely that would be difficult whilst on blockers?"

30. At 16:06 on 27th February, an administrative assistant at GenderGP emailed Patient C's mother with a copy of the second draft of the letter to the GP. She also explained that eggs were harvested by making the patient go through a very strong female cycle "to make as many eggs as possible ready to pop out of the ovaries". She warned that these eggs, once frozen, were not as fertile. The administrative assistant also gave the following additional advice:

> "It is an unknown quantity as to how long after starting testosterone fertility is affected. Some people, as you may have seen in the news, go on with masculinisation treatment and then temporarily stop it in future in order to conceive or retrieve eggs for IVF and then restart their treatment. However, we have to assume that any treatment has the potential to make you completely infertile and that this may be permanent."

The Appellant's evidence to the MPT was that she provided this information to her assistant for onward transmission to Patient C's mother.

31. At 16:52 Patient C's mother replied to the administrative assistant. She made a couple of suggested alterations to the draft letter to the GP, and added this:

> "… I'm aware of the procedure for egg retrieval/egg donation and its drawbacks fertility-wise having undergone fertility treatment myself in the past. I was more interested in the comment that [the Appellant] made below that the process can be done WHILST on blockers? That didn't seem possible to me and I just wanted to check it out?"

32. At 19:17 that evening the administrative assistant replied to Patient C's mother, stating that she would refer her question about egg retrieval whilst on blockers to the Appellant.

There is no evidence that this question was ever answered, but this was not an issue on which the Appellant was cross-examined, nor did it feature in the MPT's reasons. It therefore takes the Respondent's case no further.

33. On 29th April 2017 the Appellant prescribed puberty blockers for Patient C for the first time. There were no further communications between 27th February and that date. The treatment started in early May, and Patient C stopped taking puberty blockers in January 2018 following an apparent change of mind.

THE EVIDENCE BEFORE THE MPT

The GMC's Evidence

34. The GMC relied on evidence from a paediatric endocrinologist, Dr Daniel Klink, a specialist clinical psychologist, Dr Alanna Kierans, and a former GP and clinical lead, Dr John Dean.

35. Dr Klink's report dated 19th March 2021 was somewhat brief:

> "[Patient C] had the closest thing towards a MDT approach because there was an evaluation of a psychologist. This procedure was rather limited and from the documented communication one can draw the conclusion that the fertility issue was not adequately addressed. Assessment and decision to start treatment was not integrated within a MDT therefore according to guidelines this patient should not started endocrine treatment."

This passage is too vague, in my view, to be of much help for the purposes of para 5(d)(iii).

36. Dr Klink was not asked to expand on this opinion in his evidence in chief. Under cross-examination, Dr Klink appears to have had difficulty in getting his point across. In the end, what he was saying was that, although puberty blockers are completely reversible somatically, "once you start this path it is hard for you to deviate". In such circumstances, "there should be some assessment prior to that start of commencing that". My reading of his evidence taken as a whole is that the Appellant should have addressed the issue of fertility before Patient C started on puberty blockers notwithstanding that the potentially irreversible consequences would flow directly only from the gender-affirming treatment. There was, as he put it, a "bridging scenario".

37. Dr Klink's attention was also drawn in cross-examination to what were described by counsel as "fairly extensive email exchanges about the fertility issue". Dr Klink agreed that he had seen these emails. He was taken to a number of them but was not asked to comment.

38. Dr Kierans held the post of specialist clinical psychologist in the Gender Identity Development Service for Children and Adolescents ("KOI") in Northern Ireland between August 2014 and June 2021. Mr Jamas Hodivala KC for the Appellant suggests that it was not within her expertise to advise upon what effects medical treatment may have on fertility or to prescribe such treatment. However, in my

judgment she was qualified to assist the MPT in explaining the KOI's treatment protocols and the sort of information that should be provided to a patient in circumstances such as these.

39. Dr Kierans' report was helpful in a number of respects.

40. First of all, in the context of the issue of capacity:

> "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."

41. Secondly, in the context of the issue of fertility:

> "It appears from Dr Bouman's report that fertility was not discussed with Patient C as part of the assessment process, rather it was discussed with Patient C's mother. In my opinion this does not adequately cover the requirement of the assessing clinician to explore this topic with the young person. Although hormone blockers have a reversible effect on fertility, assigned females at birth who wish to preserve fertility by freezing eggs will have to go through this process before commencing on testosterone which is often a next step after a period of time on hormone blockers. For this reason we discuss fertility with young people in KOI as part of the initial assessment, ensuring that the young person begins to think about fertility and can be referred for fertility preservation if desired."

42. Dr Kierans expanded on this passage in her oral evidence, and what she said is set out verbatim at para 116 of the MPT's decision on impairment. Essentially, the gravamen of Dr Kierans' evidence was that good medical practice requires a discussion about fertility at the initial assessment between doctor and patient (and not just the patient's parent), for two main reasons. First, it enables the doctor to satisfy herself that the patient has capacity: that the patient is able to understand, no doubt in age-appropriate language, what the treatment entails in its various aspects. Secondly, it ensures that the patient begins to think about the ramifications of this treatment pathway in terms of his

fertility because gender-affirming hormone treatment "is often a next step after a period of time on hormone blockers". (In fact, Dr Kierans understated the probability of any patient proceeding from stage 1 to stage 2). Connected to this second reason is the fact that preservation of fertility is often a lengthy process that needs to be begun as quickly as possible to avoid delays at the second stage.

43. Dr Kierans was not asked to comment on the email exchanges between the Appellant, her administrative assistant and Patient C's mother.

44. Dr Dean's expert report did not address para 5(d)(iii). In cross-examination, Dr Dean was asked whether he had had the opportunity of looking at the various correspondence "where fertility was gone through in great detail". Dr Dean confirmed that he had, but was not asked any further questions. It follows, therefore, that counsel then appearing for the Appellant adopted the same strategy with this witness as he had done with Dr Klink and Dr Kierans. The emails were referred to but not addressed. In those circumstances, it seems to me that re-examination would have been inappropriate (*pace* Mr Hodivala's submission) and, as Mr Peter Mant for the Respondent submits, the evidence of Dr Dean (and of either or both of the other experts) cannot be taken as approving the Appellant's approach.

45. Indeed, I would go one step further. It was incumbent on counsel for the Appellant to put his positive case to at least one GMC expert that the issue of fertility was appropriately addressed in these various emails. Given that at least one of the Appellant's experts had commented on her clinical care in the light of these emails, any contrary view had to be explored. Nonetheless, I do not consider that the outcome of this appeal either can or should turn on counsel's omission.

Relevant Guidance

46. The Guidance for GPs, other clinicians and health professionals on the care of gender variant people, published by the Department of Health on 16th May 2008, stated:

> "informed consent for young people is essential. Those under 16 years old must be Fraser (Gillick) competent and, in all but the most unusual circumstances, support from parents or guardians will be required. The adverse implications of hormone blocking that are relevant for young people must be discussed fully; they include potential loss of fertility and, in female youngsters, a diminished amount of tissue available for genital surgery."

Surprisingly, the MPT was not referred to any more recent DoH guidance.

47. The Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline, first published on 9th June 2009, stated:

> "We recommend that all transsexual individuals be informed and counselled 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."

48. The Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People, published by the University of California, San Francisco, Centre of Excellence for Transgender Health, on 17th June 2016 (on which the Appellant relied) said:

> "It is recommended that transgender children and adolescents, and their guardians, also be informed and counselled regarding options for fertility preservation prior to the initiation of pubertal suppression and treatment with gender-affirming hormones… Prolonged pubertal suppression using gonadotropin hormone (GnRH) analogs is usually reversible and should not impair resumption of puberty upon cessation, though most children who undergo pubertal suppression go on to begin gender-affirming hormone therapy without undergoing natal puberty."

49. Thus, this guidance taken together seems to be clear on one point: that before undergoing puberty suppression the risks to fertility should be explained. The guidance is reasonably clear that these risks should be discussed with the patient directly and not just his parent or parents. The DoH guidance, which I would regard as particularly authoritative (and more so than guidance published overseas), recommends that informed consent should be taken from the child but that the parents too should be involved.

50. However, the guidance taken as a whole does not state that informed consent requires that the patient be told that there is a high probability that he will progress from stage 1 to stage 2. The silent premise of the guidance is that, because the patient is on a treatment pathway, it is necessary to explain the risks to fertility ensuing from the stage 2 treatment. The guidance goes no further.

The Appellant's Evidence

51. The Appellant herself accepted in cross-examination, as she had to, that the issue of fertility had not been discussed with Patient C. The Appellant referred to the various emails with Patient C's mother. She stated that she had given Patient C's mother a broad overview and had answered the questions that had been put.

52. The following exchange with the GMC's counsel is, in my view, important:

> "Q Yes, I have that. Thank you. In terms of this dialogue, was it a dialogue which involved Patient C directly, rather than it being an email communication?
>
> A No, this was a discussion between his mother and I.
>
> Q Should Patient C, who consented, I suggest to you he should have been involved in this dialogue and conversation.
>
> A The patient, I felt it was appropriate to have that discussion with the mother in this particular situation, rather than the young person.

> Q If we go back to – and we needn't go back to it, I just wanted to go back to it because I wanted to check something in my own mind, of course Patient C signs the consent, doesn't he?
>
> A He does, yes.
>
> Q Yes. So, it's not a case where you're relying on the consent of a parent to embark on prescribing. You're relying on the consent of the parent and the child.
>
> A In this situation, both mother and young person gave their consent. If you have a look back at the answer from mum on page 53 at C4c, it says fertility:
>
> "It is something we have discussed with [Patient C] he is adamant he doesn't want children but I'm not sure that's something an 11 yr old can be definite about? Blockers, though, as we understood, are not supposed to interfere with fertility are they?"
>
> So, I was quite content that mum was having these age-appropriate discussions with the patient.
>
> Q Does it follow from that that you didn't think it was necessary to have the consent of this child? You were reliant on a dialogue that you were having with the mother to communicate the content of this material ---
>
> A That's correct.
>
> Q --- to obtain the consent?
>
> A That's correct.
>
> Q Isn't that unusual, Dr Webberley?
>
> A I don't think so."

53. The Appellant was also asked questions about Patient C's possible dyslexia in the context of Dr Pasterski's psychological report. What she said was that she did not think that this meant that he was unable to consent to the treatment being considered at that time, namely puberty blockers. In addition:

> "My assessment of Patient C was that he was fully able to consent to this stage of treatment at that time. I was very happy that mum had discussed, and was able to discuss, fertility with him to a satisfactory degree."

54. The Appellant was asked a number of detailed questions by the Respondent's then counsel about the dangers of being on puberty blockers for a lengthy period, and the progression between that treatment and testosterone. The Appellant totally agreed with the proposition that one of the advantages of puberty blockers is that it gives the patient

time to think in the context of his distress having been alleviated. She also totally agreed with the proposition that there was not an automatic progression between puberty blockers and gender affirming hormones. Finally, she agreed with the following question:

> "Once you start with blockers, in a sense, the clock continues to tick, because people are then in a sense beginning, arguably, their transition by reason of the fact that their rejected puberty has been put on hold and therefore they have the comfort of knowing and the security of knowing that they're not going to go through that unwanted puberty, if I can use that shorthand."

55. The Appellant does not appear to have been asked whether she agreed with Dr Kierans' opinion that the issue of fertility should be discussed during the initial assessment because the patient is embarking on a pathway which will likely lead to cross-sex hormones which have an irreversible effect on fertility. On the other hand, the topic was addressed with the Appellant's experts.

56. After the MPT had found para 5(d)(iii) proved, the Appellant provided a reflective statement and gave further oral evidence. In cross-examination she said this:

> "I think what happened – we can see that after my consultation with Patient C and his mother, I had realised that we hadn't touched on fertility and so I went back to mother and said, "We forgot to talk about fertility. Can I get your thoughts and questions?" and we had a long back and forth discussion via email, answering her questions. Also what we have to understand here is that all patients undergo counselling regarding fertility presentation via local services. That is an ongoing discussion; it isn't a single discussion that should happen at the outset of, for example, in a ten or eleven-year-old starting puberty blockers. Although it's important to have that discussion there, because mums often have lots and lots of questions, it's a very, very ongoing discussion throughout. Whether that's before or during puberty blockers, before or during gender affirming hormones, before surgery, it's a life-long, ongoing discussion around fertility and preservation.
>
> …
>
> So fertility, have no doubt about it, is an incredibly important discourse to have. It has to be age-appropriate. We shouldn't deny somebody a particular stage of care simply because they aren't old enough or mature enough to completely understand what the future and fertility means. Again, I think it was Dr Shumer who said it can be very difficult to get these balances right. This isn't unique to transgender healthcare; this is something that doctors have faced with cancer care in young people over the years. This isn't a novel thing to transgender care.

> …
>
> I understand that it was a finding that was made and I understand that that finding was in relation to a failure to provide good care. But what I can do now is explain my recollection and the records around that care then and also relate that to the future discussions that may or would have happened with Patient C and his mother as time went on and as Patient C matured and was more able to accept, to understand information. My key message is that there isn't a one timeslot in history that this has to take place otherwise you completely miss the boat. It is an important and ongoing discussion that needs to be had."

57. Dr Daniel Shumer, a paediatric endocrinologist, agreed that prescription of puberty blockers is part of the "pathway" towards a decision about gender-affirming hormones, and he also agreed that at the relevant time the vast majority of patients did make that progression. The following exchanges in the transcript are salient:

> "I think this topic around fertility and GnRH analogues is a little more complicated because, as I said, it's not the GnRH analogues themselves that lead to the potential fertility change. So I certainly make a point to talk about what we know and what we don't know about how testosterone and oestrogen play a role on potential changes in fertility. In terms of how GnRH analogues play a role in this conversation, it's more a medication on a pathway towards a decision about another potential decision about a subsequent medication that may impact fertility. So, I don't necessarily find it egregious to not have a conversation with someone this age about fertility because, as I said, that's sort of the point of the GnRH analogues to delay decisions that are maybe out of the capacity to understand such as fertility conversations with youngsters so they can be better prepared to have those conversations when they're closer to adolescence and are thinking about medications that do impact fertility.
>
> …
>
> Q So that, I think, in a way I suggest underlines the importance that at least if there is not a detailed discussion before the child commences on blockers as part of a consent process, that issue about progress and consequence of progress should be flagged up and underlined.
>
> A Are you asking me if I agree with that?
>
> Q Yes.
>
> A Yes, again I think it's a challenging area because oftentimes I feel like the conversation about fertility when we're talking about blockers is a conversation more geared towards the parent because the child isn't equipped to understand what the heck I'm

> talking about, which is, like I said, one of the roles of the blocker is to allow that maturation to occur without progression of a dysphoric puberty so that more complicated conversations about medications that do have longer-term impacts can happen down the road.
>
> Q Just lastly on this point, whilst obviously the role of the parent, in this instance the mother, is a very important part of that dialogue and consenting, that role should never take supremacy over ensuring that the child is fully engaged and understands the process and agrees to it.
>
> A I think that the patient and parent are both essential parts of the patient-parent-provider team making these decisions, but at certain ages it is oftentimes the parents that are providing more of the information and asking more of the questions than the patient themselves."

58. Dr Shumer also said that it was his practice to have the child present at these conversations, but:

> "… that being said, it seems like the care provided in this situation was the correct care from my reading of the documentation."

59. Dr Walter Bouman, a consultant in trans health, was asked in cross-examination whether there should have been a conversation about fertility with Patient C. He said:

> "I do think that due processes have been followed and the consent form was looked at, was discussed and was signed, and that's it."

THE RESPONDENT'S CLOSING SUBMISSIONS

60. In his closing address to the MPT, counsel for the Respondent submitted that the Appellant had accepted in terms in her email of 26th February that the issue of fertility needed to be addressed. He submitted that it needed to be addressed with Patient C, that it was insufficient to do so with Patient's C's mother and via the medium of email because that was not in the nature of a proper dialogue, and that the real reason for it needing to be addressed was that "almost all people proceed from blockers into hormones". He further submitted:

> "She had to deal with it … in the context of assessing how she was going to satisfy herself that this child was Gillick competent to be able to take on board this information, and secondly, that it was going to be something that would impact on the way in which consent was addressed."

61. Counsel also submitted that the consent form was inadequate in that it failed to address the risks to fertility associated with the taking of puberty blockers: the risks were

described wholly in the context of being associated with the taking of testosterone. He added:

> "This underlines the point, we submit, made in evidence that the consent for each medical treatment should be addressed separately, and therefore the GMC ask how was this eleven year old to grapple with assessing the risks and benefits of embarking on this treatment possibly for four years without having had these matters fully explained to him in person?"

THE DETERMINATIONS OF THE MPT

62. The procedure to be followed by MPTs is set out in the General Medical Council (Fitness to Practise) Rules Order of Council 2004 (2004 SI No 2608). Under rule 17, the MPT was required to consider and announce its findings of fact and to give its reasons for those findings, and to do likewise in relation to the issues of impairment and sanction. It is standard practice for the MPT to announce its decision on the issue of misconduct, including the seriousness of that misconduct, at the same time as its decision on impairment.

63. The MPT received legal advice at various stages from the Legally Qualified Chair, Mr Angus Macpherson. No issue has been taken as to the quality of that advice.

64. In the Annex to this judgment I have set out the MPT's relevant findings of fact, as well as their reasons on the issues of misconduct, impairment and sanction. I will be analysing them later in the light of the parties' submissions.

THE LEGAL FRAMEWORK

The test on an appeal under section 40 of the Medical Act 1983

65. The parties have referred me to the well-known jurisprudence in this area. In the circumstances, I will limit my consideration to the two most recent authorities.

66. In *Sastry and Okpara v GMC* [2021] EWCA Civ 623; [2021] 1 WLR 5029, the Court of Appeal (Nicola Davies LJ giving the sole reasoned judgment) reviewed the authorities which are typically cited in section 40 appeals. Her conclusions may be summarised as follows:

    (1) This Court exercises an appellate and not a review function (paras 101; 102(ii)).

    (2) The appeal is by way of rehearing, and the Court is fully entitled to substitute its own decision for that of the MPT (para 102(iii)).

    (3) The appellate court will not defer to the judgment of the MPT more than is warranted in the circumstances (para 102(iv)).

    (4) The appellate court must decide whether the sanction imposed was appropriate and necessary in the public interest, or was excessive and disproportionate (para 102(v)).

(5) In the latter event, the appellate court should substitute some other penalty or remit the case to the MPT for reconsideration (para 102(vi)).

67. Item (3) above has, in the past, given rise to the most difficulty. A degree of deference to the expert judgment of the MPT is required (paras 103 and 104), but how much is required will depend on the circumstances and on the issue under consideration. For example, the Divisional Court in *GMC v Jagjivan* [2017] EWHC 1247 (Admin); [2017] 1 WLR 4438, in the context of an appeal under section 40A of the Medical Act 1983, stated that where the issue is dishonesty or sexual misconduct the appellate court may feel that it can assess for itself what is required in the public interest more easily than in other areas.

68. I accept Mr Mant's submission that in circumstances where the MPT has made multi-factorial decisions on the basis of nuanced assessments of fact and complex expert evidence, the appellate court should be diffident. How diffident, I would add, will depend.

69. At paras 107 and 108 of her judgment in *Sastry*, Nicola Davies LJ referred to the decision of the Court of Appeal in *Bawa-Garba v GMC* [2018] EWCA Civ 1879; [2019] 1 WLR 1929, in particular to para 67:

> "That general caution applies with particular force in the case of a specialist adjudicative body, such as the Tribunal in the present case, which (depending on the matter in issue) usually has greater experience in the field in which it operates than the courts: see *Smech* at [30]; *Khan v General Pharmaceutical Council* [2016] UKSC 64, [2017] 1 WLR 169 at [36]; *Meadow* at [197]; and *Raschid v General Medical Council* [2007] EWCA Civ 46, [2007] 1 WLR 1460 at [18]-[20]. An appeal court should only interfere with such an evaluative decision if (1) there was an error of principle in carrying out the evaluation, or (2) for any other reason, the evaluation was wrong, that is to say it was an evaluative decision which fell outside the bounds of what the adjudicative body could properly and reasonably decide: *Biogen* at 45; *Todd* at [129]; *Designers Guild Ltd v Russell Williams (Textiles) Ltd (trading as Washington DC)* [2001] FSR 11 (HL) at [29]; *Buchanan v Alba Diagnostics Ltd* [2004] UKHL 5, [2004] RPC 34 at [31]. As the authorities show, the addition of "plainly" or "clearly" to the word "wrong" adds nothing in this context."

70. However, and as Nicola Davies LJ pointed out, para 67 of *Bawa-Garba* is appropriate only to reviews under section 40A of the Medical Act 1983 and not to appeals under section 40 (para 108). In the latter context, the Court applies its own judgment, according deference or diffidence to the extent appropriate.

71. In *Sawati v GMC* [2022] EWHC 283 (Admin), Collins-Rice J, after summarising the principles in *Sastry*, added the following helpful assistance:

> "48. Since the degree of warranted deference depends on case-specific circumstances, 'material errors of fact and law will be

> corrected and the court will exercise judgment, but it is a secondary judgment as to the application of the principles to the facts of the case'. I am reminded of guidance in Gupta v GMC [2002] 1 WLR 1691 at paragraph 10 that the Tribunal has an advantage because it has had a better opportunity to judge the credibility and reliability of oral evidence given by witnesses.
>
> 49. Another important factor in the degree of deference is the expert composition of the Tribunal. Where the appellate court lacks the Tribunal's professional expertise, it must approach a challenge that a Tribunal has made 'wrong' decisions about what is necessary to protect the public, and maintain public confidence and proper standards in the profession, with a degree of 'diffidence'. But there may be matters (dishonesty or sexual misconduct are examples) where the court is likely to feel that it can assess what is needed to protect the public or maintain the reputation of the profession more easily for itself, and thus attach less weight to the expertise of the Tribunal (GMC v Jagjivan [2017] EWHC 1247 (Admin), [2017] 1 WLR 4438, at paragraphs 39-40)."

Misconduct

72. Here, the relevant principles are well-established and are not in dispute. Again, the Legally Qualified Chair directed the MPT correctly. In short, in *Roylance v GMC* (No 2) [1999] UKPC 16; [2000] 1 AC 311, Lord Clyde giving the opinion of the Privy Council stated:

> "37. The expression "serious professional misconduct" is not defined in the legislation and it is inappropriate to attempt any exhaustive definition. It is the successor of the earlier phrase used in the Medical Act 1858 "infamous conduct in a professional respect", but it was not suggested that any real difference of meaning is intended by the change of words. This is not an area in which an absolute precision can be looked for. The booklet which the General Medical Council have prepared on Professional Conduct and Discipline: Fitness to Practise, December 1993 indeed recognises the impossibility in changing circumstances and new eventualities of prescribing a complete catalogue of the forms of professional misconduct which may lead to disciplinary action. Counsel for the appellant argued that there must be some certainty in the definition so that it can be known in advance what conduct will and what will not qualify as serious professional misconduct. But while many examples can be given the list cannot be regarded as exhaustive. Moreover the Professional Conduct Committee are well placed in the light of their own experience, whether lay or professional, to decide where precisely the line falls to be drawn in the circumstances of particular cases and their skill and knowledge requires to be respected. However the essential elements of the concept can be identified.

> 38. Serious professional misconduct is presented as a distinct matter from a conviction in the British Islands of a criminal offence, which is dealt with as a separate basis for a direction by the committee in section 36(1) of the Medical Act 1983. Analysis of what is essentially a single concept requires to be undertaken with caution, but it may be useful at least to recognise the elements which the respective words contribute to it. Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word "professional" which links the misconduct to the profession of medicine. Secondly, the misconduct is qualified by the word "serious". It is not any professional misconduct which will qualify. The professional misconduct must be serious. …"

73. At para 39 of his judgment in *Calhaem v GMC* [2007] EWHC 2606 (Admin), Jackson J distilled two principles from the authorities:

> "(1) Mere negligence does not constitute "misconduct" within the meaning of section 35C(2)(a) of the Medical Act 1983. Nevertheless, and depending upon the circumstances, negligent acts or omissions which are particularly serious may amount to "misconduct".
>
> (2) A single negligent act or omission is less likely to cross the threshold of "misconduct" than multiple acts or omissions. Nevertheless, and depending upon the circumstances, a single negligent act or omission, if particularly grave, could be characterised as "misconduct"."

Impairment

74. Here, the relevant principles are those set out by Silber J in *Cohen v GMC* [2008] EWHC 581 (Admin), at paras 62-66:

> "62. Any approach to the issue of whether a doctor's fitness to practice should be regarded as "impaired" must take account of "the need to protect the individual patient, and the collective need to maintain confidence profession as well as declaring and upholding proper standards of conduct and behaviour of the public in their doctors and that public interest includes amongst other things the protection of patients, maintenance of public confidence in the profession". In my view at stage 2 when fitness to practice is being considered, the task of the Panel is to take account of the misconduct of the practitioner and then to consider it in the light of all the other relevant factors known to them in answering whether by reason of the doctor's misconduct, his or her fitness to practice has been impaired. It must not be

> forgotten that a finding in respect of fitness to practice determines whether sanctions can be imposed: section 35D of the Act.
>
> 63. I must stress that the fact that the stage 2 is separate from stage 1 shows that it was not intended that every case of misconduct found at stage1 must automatically mean that the practitioner's fitness to practice is impaired.
>
> 64. There must always be situations in which a Panel can properly conclude that the act of misconduct was an isolated error on the part of a medical practitioner and that the chance of it being repeated in the future is so remote that his or her fitness to practice has not been impaired. Indeed the Rules have been drafted on the basis that the once the Panel has found misconduct, it has to consider as a separate and discreet exercise whether the practitioner's fitness to practice has been impaired. Indeed section 35D(3) of the Act states that where the Panel finds that the practitioner's fitness to practice is not impaired, "they may nevertheless give him a warning regarding his future conduct or performance".
>
> 65. Indeed I am in respectful disagreement with the decision of the Panel which apparently concluded that it was not relevant at stage 2 to take into account the fact that the errors of the appellant were "easily remediable". I concluded that they did not consider it relevant at stage because they did not mention it in their findings at stage 2 but they did mention it at stage 3. That fact was only considered as significant by the Panel at a later stage when it was dealing with sanctions. It must be highly relevant in determining if a doctor's fitness to practice is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated. These are matters which the Panel should have considered at stage 2 but it apparently did not do so.
>
> 66. The Panel must, for example, contrary to Miss Callaghan's submissions be entitled, if not obliged, to consider if the misconduct is easily remediable in the case of the doctor concerned. If this is not so, the Panel would be precluded from considering that it was not because the doctor has psychiatric or psychological problems which mean that he will be unable to remedy the misconduct and is likely to repeat it."

75. It is relevant that in *Cohen* the doctor immediately acknowledged his error and showed full insight thereafter.

Sanction

76. In the circumstances, it is unnecessary for me to set out the relevant principles governing sanction. These are well familiar.

THE APPELLANT'S SUBMISSIONS

77. In an attractive and realistic oral argument Mr Hodivala sub-divided his submissions into a number of chapters which moved smoothly from one to the next. In a case of this complexity that made the Appellant's case easy to follow.

78. His first submission was that para 5(d)(iii) was unclear as to what it alleged, although the principal complaint appeared to be that there was no discussion about the risks to Patient C's fertility. In fact, there clearly had been some discussion, in which circumstances para 5(d)(iii) ought not to have been found proved. The paragraph did not allege that the discussions were inadequate as opposed to non-existent. Further, Mr Hodivala submitted that this paragraph did not clearly allege that the failure to provide good clinical care inhered in the failure to discuss fertility with Patient C rather than his mother; the GMC's opening failed to explain how its case was being advanced under this paragraph; and, in any event, the MPT made no adequate finding that there had been a lack of good clinical care by the Appellant because she had failed to conduct a face-to-face consultation with Patient C.

79. Mr Hodivala's second submission was that para 5(d)(iii) did not allege a want of informed consent. He drew my attention to part of the Allegation in relation to Patient B where that charge had been made. Furthermore, it is to be borne in mind that the MPT found in terms that the Head of Charge which related to Patient C and informed consent was not found proved.

80. Thirdly, Mr Hodivala submitted on the basis of the case of *AB* that it was entirely appropriate in these circumstances for the Appellant to have obtained the consent of the mother rather than of Patient C. In such circumstances, the absence of discussion with Patient C himself was legally irrelevant; on any view, there had been discussion with the mother.

81. Fourthly, Mr Hodivala submitted in writing that the MPT was wrong at paras 584-586 of its determination on the facts to find that the consent form was defective in that it failed to spell out the high likelihood of the journey by a patient in these circumstances from puberty blockers to gender-affirming hormones. The entire premise of the consent form, dealing in some detail with the risks to fertility consequent on the administration of testosterone, was that the patient would or might be making that transition. Mr Hodivala's written submissions were directed to the wrong form although he repeated these orally when the correct form was identified. In this regard he recognised that the form that the MPT analysed was "better" from the Appellant's perspective than the form that was actually signed, although he made the point that Patient C's mother was invited by the clinic to read both forms carefully.

82. Mr Hodivala submitted that what in essence this amounted to was a *different* allegation from that in fact advanced by the GMC: that the Appellant failed to explain in terms that the vast majority of patients do in fact proceed from stage 1 to stage 2.

83. Fifthly, Mr Hodivala submitted that the MPT failed to deal in a fair and accurate way with the post-consultation emails between the Appellant and Patient C. These made it clear that the risks to fertility flowing from the administration of testosterone were discussed with Patient C's mother. On all the available evidence, the Appellant was

entitled to conclude that the mother would transmit this information to her son, using age-appropriate language. The MPT made no finding to a contrary effect.

84. Sixthly, Mr Hodivala urged me to find on all the expert evidence that the Respondent's final case (as advanced in closing submissions) that (1) the discussion had to be with Patient C and not his mother, and (2) the advice given had to be in explicit terms that the "holistic pathway" (as counsel described it) was such that the vast majority of patients proceed from one stage to the next, was not made out.

85. Seventhly, Mr Hodivala made detailed submissions directed to the MPT's findings and reasons at all four stages, leading to the imposition of the sanction in June 2022. I will address those below.

THE RESPONDENT'S SUBMISSIONS

86. Mr Mant's submissions were of equally high quality. Because they were so realistic and never overstated, they were particularly compelling.

87. Mr Mant's analysis of para 5(d)(iii) was that the body of the charge alleged that the Appellant advised Patient C about the risks of puberty blockers without discussing fertility, and that the stem of the charge required an assessment of whether in those circumstances there was a want of good clinical care. The charge as framed was aimed at the advice, or lack of it, given to Patient C. The failure to give Patient C advice about fertility did not automatically mean that para 5(d)(iii) should be found proved because the stem required an evaluative assessment of that failure in the light of what was in fact done.

88. Mr Mant's written argument helpfully analysed the evidence from the various witnesses heard by the MPT. Mr Mant's submission was that the MPT accepted the evidence of Dr Kierans – described by it as "the most helpful". This evidence made it clear that the risks to fertility had to be discussed with the patient directly.

89. Mr Mant submitted that there were obvious features of the Appellant's evidence which gave rise to concern. After having failed to discuss fertility at the face-to-face consultation on 8th December, and having recognised that failure at the time, there was no attempt to contact Patient C or his mother before the consent forms were sent by email on 7th February. When the consent form was signed on 9th February, the Appellant should have been aware that, contrary to what it said, the benefits and risks had not been fully discussed and adequate knowledge on which to base inform consent had not been given. As for the flurry of emails at the end of February (my expression, not Mr Mant's), he submitted that there was nothing in them which described the likely progression or pathway from one stage to the next, there was nothing to suggest that Patient C did not wish to be involved in the decision-making, and no specific information was provided as to what the mother had told Patient C and what he understood.

90. Mr Mant acknowledged that the MPT's determinations were not as clear and detailed as they might have been, in particular the determination on the facts. He invited me to consider the determinations as a whole and against the backdrop of evidence which either was not in dispute or was clearly in support of the Respondent's case.

91. In short, the MPT's findings of fact could reasonably be interpreted as being supported by the following reasons. First, there was a requirement to discuss risks to Patient C's fertility with him before prescribing puberty blockers because most people in these circumstances proceed to stage 2 and gender-affirming hormones, the initial consultation is a key juncture, and discussing the matter from the outset gives the patient time to absorb information and reflect upon it. Further, there is a practical reason to discuss these matters early to avoid delays in preservation of fertility. Secondly, the Appellant did not discuss the risks to Patient C's fertility before prescribing puberty blockers. Thirdly, the information provided to Patient C's mother was not an adequate alternative to discussion with Patient C because the consent form did not explain that most patients proceed from stage 1 to stage 2, and "the email correspondence was not sufficient in relation to risks and consequences upon fertility of what is life-changing treatment".

92. There was a subtle difference between Mr Mant's written and oral submissions in relation to this third issue. According to the written submissions (at para 55c), consideration should be given to the information provided to Patient C and his mother. This predicates that the information provided by email to the mother would be transmitted by her in some way to her son. But – as I have already pointed out - Mr Mant's oral argument called that assumption into question.

93. As for misconduct and impairment, Mr Mant submitted that I should consider these together, because they were written and handed down at the same time. Mr Mant's interpretation of the MPT's reasons on the misconduct issue was that it concluded that the Appellant's misconduct was serious because a vast majority of patients who start on puberty blockers go on to be prescribed gender-affirming hormones, it was necessary to "get the ball rolling" in order to avoid delay in relation to later fertility preservation, and the Appellant did nothing in the five month period before she prescribed the puberty blockers to put the matter right.

94. Mr Mant stated that he could be briefer in connection with impairment and sanction. This was because, if the MPT's determination on serious misconduct were supportable, it is clear that the Appellant's insight was limited. Although she acknowledged her error, she did not say that she would change her practice.

DISCUSSION AND CONCLUSIONS

95. The MPT was being asked to deal with a case of the utmost complexity and sensitivity. There were numerous allegations which had to be addressed in a properly reasoned determination, and each of these was far from straightforward. When the case began, it would not have been in anyone's contemplation that para 5(d)(iii) would acquire the significance it did. This allegation become more and more important as the proceedings progressed, until the point was reached that it was the sole remaining issue in the case.

96. Mr Mant conceded that the MPT's reasons in support of its findings of fact were far from clear, and he made the same concession in connection with the finding of serious misconduct. Not that he put it in these terms, the MPT's reasons improved as matters proceeded. The determination on sanction is, to my mind, clear, comprehensive and balanced.

97. The fact that the MPT had so much to deal with at stage 1, when the facts were found, is a partial explanation for what I am driven to characterise as the unsatisfactory nature of its reasons at para 584-588 of the determination on the facts. Self-evidently, the MPT had to do justice to para 5(d)(iii) even if it were submerged in so much else – and much of that was more serious than what para 5(d)(iii) alleged.

98. Having made this criticism of the MPT's reasons, and it is one which I will need to justify by giving detailed reasons of my own in due course, it would be churlish and wrong for me not to recognise that the MPT has, it seems to me, been entirely fair-minded and balanced throughout this long and complex case. Any objective observer reading these determinations as a whole would have to agree that the MPT has been very fair to the Appellant. This is as far from being a hatchet job as it would be possible to be.

99. These introductory observations having been made, I turn to set out my reasoning and conclusions in relation to this appeal.

100. First of all, I begin with an analysis of para 5(d)(iii). The stem alleges a want of good clinical care. The particulars of the allegation are that the Appellant did not discuss the risk to Patient C's fertility before commencing treatment. The time-frame for that failure is "following the initial consultation" to the commencement of treatment, which in practical terms means after 9th November 2016 and before the end of April 2017. The focus is not solely on the face-to-face consultation which took place on 8th December.

101. The allegation is unclear in at least two ways. First, it is not entirely clear if the real complaint is that there was no discussion at all (i.e. with anyone), or there was a discussion but it was not with Patient C. Secondly, the risks are not specified. We know that these do not flow directly from the puberty blockers.

102. The Respondent when opening its case to the MPT did not address these issues. Instead, counsel then acting for the Respondent submitted that stage 1 and stage 2, puberty blockers and then testosterone, should be envisaged as two distinct stages in a patient's treatment, and that there should not be any form of "drift" from one to the other. The Appellant endorsed that analysis, and other concomitant issues, in cross-examination. However, it seems obvious to me that the more distinct the two stages are, and the less of a bridge there may be between the two, the lower the need to discuss the risks to fertility flowing from the administration of the testosterone at stage 2. Counsel's opening did not reflect the expert evidence the Respondent would be calling. Frankly, it did not do full justice to the Respondent's case and served to confuse the issue.

103. However, by the time closing submissions were being advanced a rather different case had emerged. In the interim, some of counsel's cross-examination of the Appellant had its eye on the opening submissions, whereas other sections followed the expert evidence.

104. The failure to open the case clearly and with full particulars is regrettable but it does not constitute a ground of appeal. The fact remains that the Appellant had every opportunity to address the Respondent's "best" case on para 5(d)(iii), and there was no prejudice. I also have some sympathy for counsel because he had so much to deal with, so many complex allegations to master, and he was no doubt far better informed when he finished than when he started. Any judge with experience of long cases at the Bar

appreciates and understands this phenomenon. The retrospectoscope is as powerful a tool in medicine as in the law.

105. So, the primary case against the Appellant was, clearly, that she failed to exercise good clinical care because she did not discuss the fertility risks with Patient C. The secondary case, which was far less clear, was probably that, regardless of with whom the discussions took place, there was no discussion of the risks to fertility consequent upon embarking on this treatment pathway. Mr Mant's interpretation of the secondary case, and it was probably the MPT's, was that it had to be made clear to the patient that there was a high chance of progression along this treatment pathway.

106. It was not in fact in dispute that fertility risks were not discussed with Patient C. However, Mr Mant accepted that the allegation could not be found proved on the straightforward basis that there was no such discussion. There *was* a discussion of sorts involving the Appellant on the other hand (either acting directly or through the agency of her administrative assistant) and Patient C's mother on the other. Mr Mant submitted that the issue for the MPT was whether this discussion, if that is what it was, was an adequate substitute for the absence of any discussion with Patient C directly.

107. I do not necessarily disagree with Mr Mant's formulation, although I would express the matter in these slightly different terms: given that (a) there were no discussions between the Appellant and Patient C about fertility, and (b) there were some discussions between the Appellant and Patient C's mother about fertility, was there a lack of good clinical care?

108. Mr Hodivala submitted that, given point (b) above (there were *some* discussions), the MPT should have found para 5(d)(iii) not proved. I reject that submission. Point (b) must be read in conjunction with point (a). Only if point (b) could exist in isolation would the point have any merit.

109. Mr Hodivala further submitted that para 5(d)(iii) did not allege a want of good clinical care in failing to obtain Patient C's informed consent. That is a stronger submission. Para 5(e) alleged precisely that, and it was found not proved. Informed consent did feature under the rubric of para 5(d)(iii) but only indirectly. Part of Dr Kierans' reasoning for her opinion that fertility risks should be discussed directly with the patient is that this enables the doctor better to assess capacity, competency and consent. However, I do not think that the Appellant's success on para 5(e) should have led to the same conclusion on para 5(d)(iii). There is a distinction between what the Head of Charge alleges (failure to discuss the fertility risks) and the reason, in part, for there being an obligation to discuss those risks.

110. Mr Hodivala further submitted that the MPT was asked to determine a different allegation, namely that the Appellant failed to advise Patient C of the high probability that he would proceed along this treatment pathway to stage 2. I am not attracted by that submission. The GMC's secondary case, as I have analysed it, does fall within the envelope of para 5(d)(iii).

111. In sum, the key issues for the MPT to resolve were, therefore, these:

(1) Was there an obligation to discuss fertility risks with Patient C directly; and, if so, why?

(2) What exactly were the fertility risks that needed to be discussed, and why?

(3) Was there an obligation to advise Patient C in terms that there was a high probability that he would proceed from stage 1 to stage 2?

(4) If the answer to (1) above is "yes", was there a want of good clinical care in all these circumstances in the light of (a) the answers to (2) and (3) above, and (b) the exchanges which did take place between the Appellant and Patient C's mother in late February 2017?

112. In addressing the first of my issues, Mr Hodivala advanced a submission of principle which had not been put forward below, based on the decision of Lieven J in *AB*. I have already summarised his argument. This is an important submission which merits careful analysis.

113. The relevant passages in *AB* state as follows:

> "67. Although there is some difference in nuance between the speeches in *Gillick*, it is accepted that Lord Scarman reflects the view of the Committee. The very essence of *Gillick* is, in my view, that a parent's right to consent or "determine" treatment cannot trump or overbear the decision of the child. Therefore, the doctors could lawfully advise and treat the child without her mother's knowledge or consent. In *Gillick*, the parent did not have the right to know that the treatment was being given, so it makes little sense to assume that the parent could act to stop the child's decision being operative on whether the treatment takes place or not. I cannot accept that Lord Scarman was drawing the distinction between the child making the decision and the parent being able to give legally operative consent that Lord Donaldson seems to have drawn in *Re R*. Mrs Gillick was asserting a right to "decide" whether her daughter could be given advice and treatment without her knowledge, and thus without her consent. Therefore, the distinction that Lord Donaldson seeks to draw between the parent retaining a right to consent, but not being in a position to determine the treatment, does not accord with the issue in *Gillick*.
>
> 68. However, in the present case, the parent and the child are in agreement. Therefore, the issue here is whether the parents' ability to consent disappears once the child achieves *Gillick* competence in respect of the specific decision even where both the parents and child agree. In my view it does not. The parents retain parental responsibility in law and the rights and duties that go with that. One of those duties is to make a decision as to consent in medical treatment cases where the child cannot do so. The parent cannot use that right to "trump" the child's decision, so much follows from *Gillick*, but if the child fails to make a decision then the parent's ability to do so continues. At the heart of the issue is that the parents' "right" to consent is always for the purpose of ensuring the child's best

> interests. If the child does not, for whatever reason, make the relevant decision then the parents continue to have the responsibility (and thus the right) to give valid consent.
>
> 69. This might arise if the child is unable to make the decision, for example is unconscious. However, it could also arise if the child declines to make the decision, perhaps because although *Gillick* competent she finds the whole situation too overwhelming and would rather her parents make the decision on her behalf. In the present case, in the light of the decision in *Bell*, and the particular issues around *Gillick* competence explained in that judgment, it has not been possible to ascertain whether the child is competent. In this case, there are two options. If the child is *Gillick* competent, she has not objected to her parent giving consent on her behalf. As such, a doctor can rely on the consent given by her parents. Alternatively, the child is not *Gillick* competent. In that case, her parents can consent on her behalf. It is not necessary for me or a doctor to investigate which route applies to give the parents authority to give consent. Therefore, in my view whether or not XY is *Gillick* competent to make the decision about PBs, her parents retain the parental right to consent to that treatment."

114. I do not interpret these passages in the same way as did Mr Hodivala. The premise of *AB* was that it was unknown whether the child was *Gillick* competent, in which circumstances the issue fell to be addressed on two alternative bases, to cover both possibilities. In the present case, we know that Patient C was *Gillick* competent because the MPT made a finding to that effect. My personal doubts about that I put to one side, as I must. In such circumstances, the consent of Patient C was required unless for whatever reason he could not give, or did not wish to give, such consent, preferring instead to defer to his mother. I consider that these propositions clearly emerge from the end of para 68 and the beginning of para 69 of Lieven J's judgment.

115. Accordingly, I do not agree with Mr Hodivala that the correct analysis of *AB* is that the ability of the parent to consent for her child exists in all circumstances and on all possible hypotheses. It does not. That would be inconsistent with *Gillick* itself. Lieven J's reference to parents retaining the right to consent to treatment was not intended to be of universal application.

116. Mr Hodivala submitted, further or alternatively, that the consent form signed by Patient C's mother and then Patient C should be interpreted in the following way: that valid consent was being given by the mother, and Patient C himself was agreeing that she should give it.

117. I consider that Mr Hodivala's argument has some force, not least because – on the assumption that this is what happened as a matter of fact – the instant case would be an example of a case, expressly recognised by Lieven J, where the child is saying in effect that he declines to make the decision, and prefers that his mother does so for him. That would be perfectly permissible, but it is not in my view what happened in the present case. The Appellant's consent form required that both the parent and the child consent to this treatment. Patient C understood that his mother was giving permission for him

to start taking puberty blockers, and – having had the consent form explained to him – he agreed to the treatment. Agreement and consent are interchangeable concepts. Patient C was acknowledging that his mother had provided consent, but he was also providing consent in his own right. What Patient C was not doing was delegating the decision to his parent. The whole purpose of having the consent form explained to him was to ensure that he was able to make the decision.

118. I consider that the Appellant's practice matched DoH guidance. This requires parental involvement in the decision-making process. There are sound practical and policy reasons why this should be so, many of which were touched on by Mr Hodivala. Here, mother and child were in agreement. In a case such as this, I am entirely comfortable with the proposition that both parent and child should be involved at all stages. At the very least, the parent needs to be present at the consultation in order, at the appropriate time, to repeat, clarify and if necessary to explain further what the doctor has said.

119. Having rejected Mr Hodivala's submission of principle, I proceed to address the expert evidence, recognising that the MPT had the benefit of seeing and hearing the witnesses, and was entitled to prefer the opinions of one or more experts over others.

120. The MPT clearly accepted Dr Kierans' evidence. I am not surprised by that. What she was saying is that there must be a discussion between doctor and patient (i.e. the child) directly about the risks to fertility consequent upon embarking on this treatment pathway, and that this discussion must take place before the treatment by puberty blockers begins. The two reasons for this obligation are that, first, a discussion of this sort will enable the doctor better to assess the patient's understanding and *Gillick* competency; and, secondly, that as the patient will likely proceed from stage 1 to stage 2, there is a need to address practical issues in relation to fertility preservation as early as possible, in order to avoid any delay later on. Moreover, these discussions will ensure that the patient is thinking about fertility from the outset. He should have no doubt that what he seeks – medical transition – may have life-changing consequences.

121. Dr Kierans' opinion is supported by the guidance I have set out. I do not understand from the transcript that Dr Shuman really took issue with most of what Dr Kierans said, although he did not think that it was incumbent on the doctor to have these discussions with the patient as opposed to a parent. In his practice, however, the child is directly involved. Dr Shuman did place greater emphasis on the practical difficulty in having these discussions because fertility and the risk to it will be beyond the intellect, emotional resources and imagination of most children so young. This was the dilemma that the MPT expressly recognised.

122. That said, the practical difficulty cannot and should not be overstated. Doing so might lead to the conclusion that these treatments should never be offered to the younger age-group, which was not Dr Shuman's evidence, nor was it the Respondent's case.

123. Dr Kierans' opinion was that discussions about fertility should be with the patient *directly* (not of course excluding the involvement of parents). Her reason was that such discussions would enable the doctor better to assess capacity. I will be returning to the question of whether discussions with a parent alone could ever be an adequate substitute, but at this stage I make the following observation. Given the Appellant's assessment that Patient C was *Gillick* competent, and given also that he did not cede his

decision-making autonomy to his mother, it seems to me that for this reason alone the Appellant did owe a duty to discuss the risks to fertility with Patient C directly.

124. The risks to Patient C's fertility did not flow from the puberty blockers: their effects were fully reversible. They flowed from the gender-affirming hormone treatment, informed consent for which would require a separate exercise at the relevant time. However, risks to fertility arose because Patient C was embarking on a treatment pathway which would very likely lead to the next stage. How exactly should these subtle and complex issues be addressed?

125. In my judgment, and contrary to Mr Mant's submission, it would be a step too far to hold that the doctor should explain *in terms* that there is at least a 90% chance of progression. That was not Dr Kierans' evidence, nor does it appear in any guidance. There are obvious disadvantages in giving out figures of this sort, not least because that might enhance the risk of some sort of inexorable progression (the very "drift" characterised by the Respondent's counsel in this opening to the MPT) as well as understate the requirement for a fully-informed and open-minded consent process before stage 2.

126. However, one way or another the patient does have to understand why fertility is being talked about before any treatment begins, in circumstances where at stage 1 there are no risks. In my judgment, the patient needs to understand that he is beginning on a pathway or journey with at least two possible stages, although he may decide in due course that he will not proceed beyond stage 1. Before commencing on this journey, he needs to understand in general terms what the risks are at each stage, because – equipped with that information and knowledge – he may decide not to start the journey at all. This is what properly informed consent means in these circumstances.

127. This is an appropriate moment to take stock in the context of the four issues I have identified (see §111 above). In my judgment:

(1) The Appellant owed a duty to discuss the fertility risks with Patient C directly.

(2) Patient C needed to understand how and why these risks arose. He needed to understand that although the effects of puberty blocks were reversible, the effects of gender-affirming treatment may well not be. The reason why these risks were being discussed now was because Patient C was embarking on a journey, a treatment pathway, which if he continued to want would lead to gender transition. There was no obligation to inform Patient C in explicit terms that the vast majority of patients in fact proceed from the blockers to the hormones.

128. This deals with my first, second and third issues.

129. Thus far, I have been applying and interpreting the expert evidence that the MPT found compelling, perhaps adding the occasional gloss and exegesis of my own. However, in order to begin to answer the fourth of the questions I have posed (see §111 above), I must address and analyse the MPT's reasons and findings.

130. Para 584 of the MPT's determination of fact is unobjectionable, insofar as it goes. It was not in dispute that treatment proceeds in stages, that the vast majority of patients

request gender-affirming hormones, and that "in some cases" stage 2 interventions may be irreversible.

131. At paras 585-586 the MPT addressed the consent form. A number of issues arise here. First, the Appellant had not been asked questions about the adequacy of her consent form. Secondly, I have seen no indication in the available transcripts that any expert was asked questions about it. The issue certainly featured in the Respondent's counsel's closing submissions, but that was too late. Thirdly, although this was not the MPT's fault, it addressed the wrong form. Fourthly, I think that the MPT misunderstood the form it did consider. The patient was clearly advised of the risks to fertility from testosterone treatment. Contrary to para 586 of the reasons, "the seriousness of or the profound impact of the [hormone] treatment" *was* set out – at para 4 of the form in particular. True, the likelihood of progression from stage 1 to stage 2 was not explained, but for the reasons I have given there was no requirement to go that far. The whole premise of the form was that the patient was embarking on a journey.

132. My fifth point is that the MPT was not of course able to conduct any analysis of the correct form. In my judgment, this form does not explain the risks to fertility consequent upon testosterone treatment. The first bullet point on the second page of the form does state, "my doctor has talked with me about the benefits and risks of puberty blockers, the possible or likely consequences of hormone therapy …" but nowhere in the form are those risks explained. Thus, what the consent form is assuming is that these risks will be separately explained by the doctor and discussed with the patient. Finally, I should state that the form does make it tolerably clear, at least by necessary implication, that the patient is now embarking on a pathway or journey.

133. I propose to strike out paras 585-586 of the MPT's reasons and not substitute any findings of my own, based as they would have to be on the correct form. My diffidence stems from a number of considerations, the main one being that I do not have the benefit of any expert evidence on the correct form, and insofar as I am making criticisms of the Appellant on a basis which was not considered by the MPT, it would not be right to deploy these against her.

134. I am certainly able to accept Mr Mant's submission that notionally striking out these paragraphs cannot lead without more to my allowing this appeal. Although para 585-586 betray significant errors and misunderstandings which appear to have been used against the Appellant by the MPT (and which also feed into para 588), there may be independent reasons justifying the MPT's findings of fact.

135. At para 587 the MPT stated that it had regard to the email correspondence between "Dr Webberley's clinic" and Patient C's mother. I do not know if the MPT was making the (false) point that not all of the correspondence came from the Appellant herself, and for that reason was irrelevant. More importantly, the MPT omitted any reference to the email from the administrative assistant, written on the Appellant's instructions, advising the recipient of the risk to fertility from testosterone treatment. That email could not have been clearer.

136. This brings me to para 588 of the MPT's reasons, which at this juncture I set out in full:

> "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."

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.