

PUBLIC RECORD**Dates:** 26/08/2025 - 08/09/2025

Doctor: Dr Joseph ONWUDE

GMC reference number: 3608119

Primary medical qualification: MB BS 1981 University of Ibadan

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

Summary of outcome

Erasure

Immediate order imposed

Tribunal:

| | |
|-----------------------------|------------------|
| Legally Qualified Chair | Mrs Aaminah Khan |
| Lay Tribunal Member: | Mr George McLean |
| Registrant Tribunal Member: | Dr Emma Sellars |

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| Tribunal Clerk: | Ms Hinna Safdar |
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Attendance and Representation:

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|---------------------|---|
| Doctor: | Present, not represented |
| GMC Representative: | Mr Robin Kitching, Counsel (26 August 2025 – 5 September 2025) Mr Adam Lodge, Counsel (8 September 2025) |

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts - 05/09/2025

Background

1. Dr Onwude, a consultant gynaecologist, qualified in 1981 from the University of Ibadan in Nigeria.
2. The allegation that has led to Dr Onwude's hearing is that in March and April 2022, Dr Onwude issued private prescriptions to Patients B and C, as well as treating Patient D by inserting an HRT implant, when he did not hold a licence to practise medicine. It is also alleged that Dr Onwude subsequently issued a further prescription to Patient E in November 2022, when he did not hold a licence to practise and his registration with the GMC had been suspended. Further, that when that prescription was refused by a pharmacist, he told her he was entitled to prescribe and he would tell Patient E to take the prescription elsewhere. It is alleged that Dr Onwude's conduct was dishonest. It is further alleged that on 26 March 2024, at Suffolk Magistrates' Court, Dr Onwude was convicted of engaging in conduct calculated to suggest that he had a licence to practise when he did not. It is alleged that on 29 November 2024, on his Appeal at the Ipswich Crown Court (where the appeal against conviction was dismissed), Dr Onwude was ordered to pay compensation of £1200 and a fine of £180.
3. The GMC received a referral from Well Pharmacy in November 2022.

The Outcome of Applications Made during the Facts Stage

4. The Tribunal refused Dr Onwude's application made pursuant to Rule 17(2)g of the of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), that there was no case to answer in relation to several of the paragraphs of the Allegation. The Tribunal's full decision is set out in Annex A. The Tribunal granted the GMC's application to amend the Allegation by adding a further paragraph relating to the dishonesty allegations (paragraph 17) which had been omitted due to an administrative error and to change the name of the Patient from D to E (in paragraphs 11, 12 and 13). The Tribunal was minded to grant the application in full as it was satisfied that all of the amendments sought could be made without injustice to Dr Onwude.

The Allegation and the Doctor's Response

5. The Allegation made against Dr Onwude is as follows:

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

Misconduct

1. On 26 March 2022 you sent an email to Patient A in which you referred to HRT medication as '*smarties*', and in so doing you diminished the importance of the risks and benefits of the treatment. **Admitted and found proved**
2. On 31 March 2022 you issued a private prescription for anti-viral medication for Patient B without:
 - a. An adequate assessment of Patient B; **Admitted and found proved**
 - b. obtaining an adequate medical history, including any allergies. **Admitted and found proved**
3. On 31 March 2022 you issued a private prescription for anti-viral medication for Patient C without:
 - a. An adequate assessment of Patient C; **To be determined**
 - b. obtaining an adequate medical history, including any allergies. **To be determined**

4. Your action in issuing the prescriptions as set out at paragraphs 2-3 above gave the impression you were a fully registered practitioner with a licence to practice. **To be determined**
5. You were not entitled to write the prescriptions in paragraphs 2 and 3 because you:
 - a. did not hold a licence to practise; **To be determined**
 - b. required a licence to practise in order to prescribe. **To be determined**
6. When you wrote the prescriptions in paragraphs 2 and 3 you knew;
 - a. that you did not hold a licence to practice **Admitted and found proved**
 - b. that you needed to hold a licence to practice in order to prescribe **To be determined**
7. Your conduct in paragraphs 2-3 and 4 above was dishonest by reason of paragraphs 5 and 6. **To be determined**
8. On 1 April 2022 you sent a text message to Patient D which included the addresses of other Patients and details of appointment dates and times with them, in breach of those Patients' confidentiality. **Admitted and found proved**
9. On 2 April 2022 you treated Patient D by injecting her with an HRT implant. **Admitted and found proved**
10. You failed to obtain Patient D's fully informed consent to the treatment in paragraph 9 above in that:
 - a. treating Patient D as set out at paragraph 9 gave the impression you were a fully registered practitioner with a licence to practise; **To be determined**
 - b. you did not inform Patient D that you did not hold a licence to practise; **To be determined**
 - c. you did not hold a licence to practise. **To be determined**
11. You wrote and gave to patient ~~D~~ E a private prescription (the prescription) 10mg Vagifem, which you signed and dated 10 November 2022 giving the impression

you were a fully registered practitioner with a licence to practise. **Amended under Rule 17(6)**

To be determined

12. You were not entitled to write or give the prescription to Patient D E because:
Amended under Rule 17(6)
 - a. you did not hold a licence to practise; **To be determined**
 - b. you required a licence to practise in order to prescribe; **To be determined**
 - c. your Registration with the General Medical Council had been suspended.
To be determined
13. When you wrote and gave the prescription to Patient D E you knew that:
Amended under Rule 17(6)
 - a. you did not hold a licence to practise; **To be determined**
 - b. you needed to hold a licence to practise in order to prescribe; **To be determined**
 - c. your Registration with the General Medical Council had been suspended;
To be determined
 - d. you needed Registration with the General Medical Council. **To be determined**
14. Your conduct in paragraph 11 was dishonest for the reasons set out in paragraphs 12 and 13. **To be determined**
15. On 17 November 2022 the Responsible Pharmacist at Well Pharmacy contacted you about the prescription to confirm, as your registration status had been suspended, the prescription could not be legally dispensed. You told the pharmacist that you:
 - a. were entitled to prescribe; **Admitted and found proved**

- b. would tell the Patient to take the prescription elsewhere for dispensing.

Admitted and found proved

16. You knew that you were not entitled to prescribe. **To be determined**

17. Your conduct in paragraph 15a-b was dishonest for the reason set out in paragraph 16.

Amended under Rule 17(6)

To be determined

Conviction

18. **Amended under Rule 17(6)** On 26 March 2024 at Suffolk Magistrates' Court you were convicted of, on 02/04/2022 at Badwell Ash, being a person not holding a licence to practise engaged in conduct calculated to suggest that you had such a licence, in that performing HRT surgery and administering HRT medication to [Patient D] contrary to s.49A(1) Medical Act 1983. **Admitted and found proved**

19. **Amended under Rule 17(6)** On 29 November 2024 on your Appeal at the Ipswich Crown Court, you were ordered to pay:

- a. compensation of £1200; **Admitted and found proved**

- b. a fine of £180. **Admitted and found proved**

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

- a. misconduct in respect of paragraphs 1-16; **To be determined**

- b. conviction in respect of paragraphs 17 - 18. **To be determined**

The Admitted Facts

6. At the outset of these proceedings, Dr Onwude made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules').

In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

7. In light of Dr Onwude's response to the Allegation made against him the Tribunal is required to evaluate the remainder of the facts to be determined.

Evidence

8. The Tribunal received oral evidence and witness statements on behalf of the GMC from the following witnesses:

- Mr H, an Investigation Officer at the General Medical Council
- Mr G, a Consultant Obstetrician and Gynaecologist and expert witness for the GMC
- Patient D
- Ms F, the pharmacist on duty at the Well Pharmacy store ('the Pharmacy') on 17 November 2022

9. Dr Onwude provided his own witness statement, dated 10 June 2024 and he also gave oral evidence at the hearing.

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

- Determination of Interim Order Tribunal – Order of Suspension, dated 10 August 2022
- Determination of Interim Order Tribunal – Order of suspension maintained, dated 21 July 2023
- Certificate of Conviction – Ipswich Magistrates Court, dated 25 June 2025
- Medical Records – Patient D – dated 2 April 2022 to 12 August 2024
- Mr G's expert report, dated 17 December 2024
- Result of Appeal before Ipswich Crown Court, dated 4 December 2024
- Appeal of conviction (Court of Appeal submission), dated 1 January 2025, including
 - Submission document
 - Result of Appeal Ipswich Crown Court
 - Submission Letter
- Ipswich Crown Court - Appeal Outcome and Reasoning, dated 8 January 2025

- Ipswich Crown Court - Certificate of Conviction and Appeal Outcome, dated 8 January 2025
- Suffolk Police Investigation Documents (MG5, MG11, Interview Record), dated 31 January 2025
- Ipswich Crown Court – approved transcript of Appeal Hearing, dated 29 November 2024
- Patient records produced by Dr Onwude purporting to be for Patient C
- Prosecution opening note with prescriptions attached, dated 17 September 2024
- Various correspondence between Dr Onwude and the GMC

The Tribunal's Approach

11. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Onwude does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e., whether it is more likely than not that the events occurred.

12. The Tribunal has had regard to the test of dishonesty set out in *Ivey v Genting Casinos (UK) Limited (t/a Crockfords Club)* [2017] UKSC 67, which states:

1. *The Tribunal must first ascertain (subjectively) the state of the individual's knowledge or belief as to the facts. The reasonableness of the belief is a matter of evidence going to whether she genuinely held the belief, but it is not a requirement that the belief must be reasonable.*

2. *Secondly, the Tribunal must then consider whether that conduct was dishonest by the (objective) standards of ordinary and honest people. There is no requirement that the individual must appreciate that what they have done was, by those standards, dishonest.*

The Tribunal's Analysis of the Evidence and Findings

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

Paragraph 1

14. Despite this paragraph of the Allegation being admitted at the outset of the hearing by Dr Onwude, he disputed it throughout his evidence. The Tribunal was of the view that the earlier admission could not be relied upon and it treated it as a denied paragraph of the Allegation.

15. Dr Onwude's position was that his admission was limited solely to the act of sending an email to Patient A in which he used the term '*smarties*' in relation to HRT medication. He sought to argue that the term HRT (hormone replacement therapy) was not accurate and that he was referring to ERT (estrogen replacement therapy). He said HRT involved progesterone and estrogen and ERT was for patients who did not have a womb. When asked about whether he accepted that ERT was a form of HRT, he maintained that to refer to HRT in this context was '*illiterate*'. Dr Onwude disagreed that by referring to the medication as '*smarties*' this diminished the importance of the risks and benefits of the treatment. He stated that he used that term with his patients and only one patient had complained out of hundreds.

16. In relation to the first issue disputed by Dr Onwude, that to use the word 'HRT' was inaccurate, the Tribunal considered that HRT was essentially an umbrella term, which was commonly used by patients (as can be seen from Patient A's email quoted below) as well as the medical profession, and that to refer to HRT rather than ERT was not inaccurate. For the same reasons set out when the submission of no case to answer was considered (as set out in Annex A), the Tribunal considered that Dr Onwude was making a distinction without a meaningful difference. Estrogen is a hormone so ERT is a form of HRT.

17. The Tribunal next considered whether Dr Onwude referring to the HRT medicine as '*smarties*' diminished the importance of the risks and benefits of the treatment. The Tribunal considered Dr Onwude's position on this against the full body of evidence, which included a direct reaction from Patient A to the email in question. Patient A's response, which stated, "*Joe. Please don't refer to serious HRT medication as 'Smarties'. I have raised this with you before. It looks unprofessional & makes you look like a lightweight joker & makes us as recipients seem inconsequential*". The Tribunal considered that this was particularly persuasive as it was direct evidence of the reaction from a patient to Dr Onwude's use of the term. The Tribunal agreed with Patient A's assessment that such language had the effect of making patients feel inconsequential and that it was unprofessional.

18. Furthermore, the Tribunal found that referring to prescription only medication in this jovial and casual manner had the effect of minimising and diminishing the significant risks associated with HRT treatment, a point which was supported by the expert evidence of Mr G. Mr G's opinion was that such informal language trivialises the necessary careful consideration that both a doctor and patient must give to weighing the risks and benefits of any prescribed treatment; a view with which the Tribunal agreed.

19. Consequently, the Tribunal determined that by using this term, Dr Onwude did indeed diminish the importance of the risks and benefits of the treatment. It therefore determined that Paragraph 1 of the Allegation was proved.

Paragraph 3

20. The Tribunal considered the evidence regarding the prescription of anti-viral medication for Patient C. Dr Onwude accepted that he had issued the private prescription for Patient C, the teenage daughter of Patient D, for anti-viral medication, as she had been suffering from COVID-19. However, he disputed this part of the allegation (and had admitted an identical allegation for Patient B) on the basis that he had previously provided medical treatment to Patient C and because of the past doctor/patient relationship, he did not need to carry out an assessment or obtain a medical history prior to prescribing the anti-viral medication. Dr Onwude produced medical records in support of his case, which he purported were for Patient C. However, the initials, date of birth and age of the patient in those records did not match, and the evidence of Patient D was that those records were for her much older step-daughter, not Patient C (whom he had only seen once several years earlier).

21. The Tribunal took the view that although Dr Onwude had conducted a prior assessment for Patient C several years earlier concerning a separate matter of acne, this historical consultation could not possibly be considered a suitable, contemporaneous assessment of Patient C's clinical condition and so could not form an adequate basis for prescribing a new and different medication. A fresh and thorough assessment was imperative, particularly given the passage of time during which Patient C's medical history, including the development of any new conditions or allergies, could have significantly changed. This perspective was strongly supported by the expert testimony of Mr G, who in his report stated, *"Patient.... states that Dr JO prescribed anti-viral tablets for her husband and daughter. There is no mention that he obtained any details about them, such as a basic medical history, assessment of their clinical condition and any allergies and wrote her daughter's date of birth incorrectly on the prescription. This would be considered seriously*

below the standard expected of a consultant gynaecologist as it represents unsafe and irresponsible use of medication.”

22. The Tribunal agreed with Mr G’s view, concluding that Dr Onwude’s issuing of a private prescription for Patient C, who was still a minor, was without an adequate assessment or without obtaining an adequate medical history, including any allergies. The Tribunal therefore determined that Paragraph 3(a) and (b) of the Allegation was proved.

Paragraph 4

23. The Tribunal considered the matter of whether Dr Onwude’s actions in issuing the prescriptions gave the impression he was a fully registered practitioner with a licence to practise. It heard oral evidence and received a witness statement from Patient D, who was clear that she was not aware Dr Onwude was unlicensed at the relevant time that the prescriptions were issued in March/April 2022.

24. In his defence, Dr Onwude sought to rely on an opening statement document from the Crown Prosecution Service (CPS) from his criminal trial; however, the Tribunal noted that, as detailed in Annex A, he had misquoted this document, which did not fully set out Patient D’s evidence in her police witness statement. For the same reasons as set out in Annex A, the Tribunal did not consider that this undermined the clear evidence of Patient D that, whilst she had been aware of more historic issues that Dr Onwude had with the GMC in 2014-2016, she understood that those had been resolved in Dr Onwude’s favour and that in April 2022 she was under the impression that he had a licence to practise, only realising that he did not when the pharmacist refused the prescription the following week. The Tribunal considered that the evidence of Patient D supported that Dr Onwude’s actions in issuing the prescriptions gave the impression that he was a fully registered practitioner with a licence to practise.

25. Additionally, the Tribunal determined that it was a clear and logical inference to draw that any patient, when presented with a prescription written by an individual they know to be a doctor, would assume that individual possesses the necessary registration and licence to practise and prescribe. By undertaking the act of writing a prescription, which is a fundamental and protected privilege of a licensed medical practitioner, Dr Onwude inherently created the impression that he was entitled to do so. The Tribunal therefore determined that Paragraph 4 of the Allegation was proved

Paragraph 5

26. In his evidence before the Tribunal, Dr Onwude formally admitted that he did not, in fact, hold a licence to practise at the material time when he wrote the prescriptions. However, he sought to advance a defence by stating that he did not require one for his actions, for a number of legal arguments that are set out in Annex A.

27. The Tribunal gave careful consideration to this submission but found it to be unfounded and entirely without merit. The Tribunal had regard to the official guidance issued by the GMC, which it determined was unequivocal and clear on the requirements for doctors to have a licence to practise in order to prescribe. The Tribunal was mindful that GMC guidance does not have legal effect and it is a matter for the Tribunal to decide as to whether a licence is required to prescribe. However, the Tribunal was in agreement with the GMC guidance.

28. The Tribunal was firmly of the view that the activities of prescribing prescription-only medications and carrying out procedures, such as implanting HRT pellets, are straightforward and fundamental examples of medical practice which would require a licence to practise. These are not peripheral or ambiguous tasks; they are core, regulated activities that lie at the very heart of what constitutes the practice of medicine. Consequently, the Tribunal found that a licence to practise was an absolute and non-negotiable prerequisite for any doctor undertaking such actions and determined that paragraphs 5(a) and 5(b) of the Allegation were proved.

Paragraph 6

29. The Tribunal carefully considered Dr Onwude's oral evidence regarding his knowledge and belief at the relevant time, as well as the correspondence between the GMC and Dr Onwude concerning his licence status.

30. In his evidence, Dr Onwude maintained that he had not received a number of these emails; however, the Tribunal did not find that Dr Onwude's evidence was reliable nor consistent. Specifically, the Tribunal noted that in response to one of the GMC emails, Dr Onwude had replied suggesting that perhaps it was time for him to retire, a response which the Tribunal considered proves that he had received and engaged with at least that specific communication and showed that at that time (June 2021) Dr Onwude knew that he needed a licence to practise to continue treating patients. However, when cross-examined about what

impact he thought the withdrawal of his licence would have on his practice he did not accept that he was aware there would be any impact (which was at odds with his email suggesting he may have to retire).

31. The Tribunal noted that the GMC had been in regular correspondence with Dr Onwude from December 2020 regarding the needs to provide annual returns, which Dr Onwude had not acknowledged, responded to, or challenged. It found the body of correspondence made it unequivocally clear that from at least June 2021, Dr Onwude knew that he required a licence to practise. The Tribunal formed the view that there was ample and sufficient evidence to conclude that by March 2022, at the time of the events concerning Patient D and her family, Dr Onwude was fully aware that he needed a licence in order to prescribe and practise. Dr Onwude had raised several (unfounded) technical legal arguments to seek to argue why he did not need to have a licence. However, on his own evidence, he admitted that he only looked at the detail of the Regulations and started to raise these legal points many months after the events in question. It found that his denial of this knowledge was not credible, agreeing with the GMC characterisation of his subsequent legal arguments as a ‘smokescreen’ developed only after he encountered difficulty with these complaints.

32. The Tribunal was satisfied to the required standard, that Dr Onwude’s knowledge of the requirement for a licence in order to prescribe was established. The Tribunal therefore determined that Paragraph 6(b) of the Allegation was proved.

Paragraph 7

33. Having already found as facts that Dr Onwude knew he did not hold a licence to practise and, crucially, that he knew he needed one in order to prescribe, the Tribunal applied the test for dishonesty as set out in the case of *Ivey v Genting Casinos*. The first stage of this test was to ascertain Dr Onwude's actual state of knowledge and belief, which the Tribunal had established in relation to Paragraph 6. The second stage was to consider whether, by the standards of ordinary decent people, his conduct in issuing the prescriptions while possessing that knowledge was dishonest.

34. The Tribunal was unequivocal in its view that, applying this test, Dr Onwude’s conduct was dishonest. A registered doctor, aware that they are prohibited from performing a core professional function, yet who deliberately undertakes that function regardless, would be considered by ordinary decent people to have acted dishonestly. By presenting himself through his actions as being entitled to prescribe, he deliberately deceived the patients and

the pharmacists involved, creating a false impression to which he knew he was not entitled. Therefore, the Tribunal concluded that his conduct was fundamentally dishonest and determined that Paragraph 7 of the Allegation was proved.

Paragraph 10

35. The Tribunal's determination on this allegation was informed by the fact of Dr Onwude's criminal conviction, which directly related to the treatment of Patient D. The Tribunal noted that the specific factual components of sub-paragraphs 10(a) (that the treatment gave the impression he was a licensed practitioner), 10(c) (that he did not hold a licence to practise), and 10(b) (that he did not inform Patient D of this fact), were all proven by the conviction (not as elements of the offence itself but from the Judge's findings made in that case). The central issue before the Tribunal was therefore whether the circumstances in (a) – (c) invalidated the consent that was given.

36. The Tribunal reasoned that for consent to be fully informed, a patient must be in possession of all material information relevant to their decision. The legal status and authorisation of the individual performing a procedure is fundamentally material information, as it goes directly to the safety, legitimacy, and very nature of the treatment being offered. Consequently, the Tribunal found that by withholding the critical information that he was not licensed to practise, Dr Onwude deprived Patient D of the opportunity to make a truly informed choice. The fact that it was material information is supported by Patient D's evidence that she would not have agreed to undergo the procedure had she known that Dr Onwude did not have a licence. As she could not have consented to a procedure performed by an unlicensed practitioner without being made aware of that fact, her consent was rendered invalid. The Tribunal determined that Paragraph 10 was proved in its entirety.

Paragraph 11

37. The Tribunal was satisfied on the basis of the evidence before it that Patient E was a distinct individual from Patient D. This was apparent from the clear evidence of Patient D and consideration of the different prescriptions, which were in different style and form. The Tribunal considered Dr Onwude's explanation for the 10 November 2022 prescription, which was that it might have been written and post-dated several months earlier in March and presented to Ms F at the Well pharmacy in Brentwood by Patient D. However, the Tribunal found this account to be implausible and contrary to Patient D's clear evidence that she had not attended that pharmacy in the last five years. It noted several key factors that

undermined his explanation: the prescription was produced on different paper to the one in March, it was printed whereas the March prescription was handwritten, and Dr Onwude himself could not recall when he had actually written it. There was no logic as to why Dr Onwude would have dated the prescription 10 November 2022, if he was writing it in March 2022. Crucially, the evidence from Patient D was that Dr Onwude had given her in March 2022 only a single prescription, and the pharmacy to which Patient E's prescription presented was located a drive of an hour and a half away, making the suggestion of a pre-written, post-dated prescription, for a date approximately seven and a half months later, highly impractical and unlikely.

38. The Tribunal concluded that these were indeed two separate patients and that it was likely that the prescription for Patient E was created around the date it bore, 10 November 2022, as a clear inference could be drawn that was the case from the finding that Patient D and E were different patients, the prescription was presented a week after it was dated and Dr Onwude's own evidence that he could only recall post-dating prescriptions for Patient D. Furthermore, the Tribunal applied its earlier finding from paragraph 4 of the allegations, which established that the act of writing a prescription inherently gives the impression that the prescriber is a fully registered and licensed practitioner. Additionally, there was no material reason as to why the date in November was selected by Dr Onwude, making no logical sense. The Tribunal therefore determined that Paragraph 11 of the Allegation was proved.

Paragraph 12

39. Relating to 12(a) and 12(b), which state that Dr Onwude was not entitled to write the prescription because he did not hold a licence to practise and that he required one to prescribe, the Tribunal deemed its findings from Paragraph 5 of the allegations to be directly relevant and applicable to this paragraph of the Allegation. Having already definitively established that a licence is an absolute requirement for prescribing and that Dr Onwude did not hold one, the Tribunal applied that same reasoning to this specific instance. Regarding 12(c), which concerned the suspension of his registration, the Tribunal examined the specific chronology of events. The prescription for Patient E was dated 10 November 2022 and was presented to the pharmacy by the patient on 17 November 2022.

40. The Tribunal, having already rejected Dr Onwude's explanation that the prescription was post-dated, found that there was a strong inference and that it was more likely than not that the prescription was generated on or around the date it bore, namely 10 November. As

this date fell after the GMC had suspended his registration on 10 August 2022, the Tribunal was satisfied that Dr Onwude was not entitled to write the prescription, as his registration had been suspended, an action which explicitly prohibits all practise, including prescribing. The Tribunal found Paragraph 12 proved in its entirety.

Paragraph 13

41. The Tribunal's determination on Dr Onwude's knowledge at the time he wrote the prescription for Patient E was informed by its previous, clear findings on his state of awareness. For 13(a), 13(b), and 13(c), which pertain to his knowledge that he did not hold a licence, that he needed one to prescribe, and that his registration had been suspended, the Tribunal found its prior conclusions in paragraphs 5 and 6 of the allegations to be directly relevant and applicable. Having already established that Dr Onwude knew he was unlicensed and required a licence to practise, and that he was aware of the suspension of his registration (having attended the Interim Orders Tribunal (IOT) hearing where the suspension was imposed), the Tribunal logically extended these findings to this later event.

42. Specifically for 13(d), which required proof that he knew he needed registration with the GMC, the Tribunal referred to the explicit and unambiguous language contained in the GMC's correspondence to him following the IOT hearing when the suspension was imposed. This letter stated, *"you should not undertake activities, such as prescribing or signing statutory certificates while you are suspended."* The Tribunal found that this directive made it incontrovertibly clear that registration was a fundamental prerequisite for any medical practice, including prescribing. By receiving this communication, Dr Onwude was therefore on clear notice of the necessity of registration. The Tribunal therefore determined that Paragraph 13 of the Allegation was proved in its entirety.

Paragraph 14

43. The Tribunal considered that a finding of dishonesty in relation to the prescription for Patient E was the inevitable consequence of its established factual conclusions from the preceding allegations. The Tribunal had already definitively determined in paragraph 12 that Dr Onwude was not entitled to write the prescription because he did not hold a licence, he required one to prescribe, and his registration was suspended.

44. Furthermore, in its findings relating to paragraph 13, the Tribunal had conclusively found that at the time of writing the prescription, Dr Onwude knew each of these facts; he

was aware of his lack of a licence, his need for one, his suspended status, and the necessity of registration.

45. Applying the legal test for dishonesty from *Ivey v Genting Casinos*, the Tribunal first ascertained this actual state of knowledge as established by the evidence. It then considered whether, by the standards of ordinary decent people, issuing a prescription in such circumstances—knowing one is completely prohibited from doing so and is misrepresenting one's authority to a patient and a pharmacy—would be considered dishonest. The Tribunal was unequivocal in its view that it would. His actions in issuing and handing over the prescription were in those circumstances, calculated to suggest he possessed an authority he knew he had been stripped of, thereby misleading Patient E and the dispensing pharmacist and would be considered dishonest by the standards of ordinary decent people. The Tribunal determined that Paragraph 14 of the Allegation was proved.

Paragraph 16

46. The Tribunal was satisfied on the evidence before it that Dr Onwude knew that he was not entitled to prescribe (contrary to what he asserted during his conversation with the pharmacist, Ms F) and this was a direct and logical extension of its previous findings. For the reasons set out in detail within paragraph 13, the Tribunal had already established that Dr Onwude possessed the specific knowledge that he did not hold a licence to practise, that he needed one to prescribe, that his registration had been suspended, and that he needed that registration with the GMC, at the time he wrote the prescription for Patient E.

47. The conversation with Ms F occurred on 17 November 2022, which was after the issue of that prescription and within the same period of his suspension. The Tribunal therefore found it an inescapable inference that this knowledge was present and current in his mind during his interaction with the pharmacist. When he explicitly told Ms F that he was entitled to prescribe and that the patient should take the prescription elsewhere, he did so with the full understanding that these statements were false. Consequently, the Tribunal was satisfied that at the precise moment of this exchange, Dr Onwude knew he was not entitled to prescribe and determined that Paragraph 16 of the Allegation was proved.

Paragraph 17

48. The Tribunal considered that a finding of dishonesty in relation to the conversation with Ms F flowed directly from its conclusive determination on Dr Onwude's state of knowledge as set out in paragraph 16.

49. Having already established that Dr Onwude knew he was not entitled to prescribe when he spoke to Ms F, the Tribunal applied the two-stage test for dishonesty from *Ivey v Genting Casinos*. The first stage was to ascertain his actual state of knowledge, which was that his suspension made it unlawful for him to prescribe and that his statements to the contrary were false. The second stage required the Tribunal to consider whether, by the standards of ordinary decent people, his conduct in that conversation was dishonest. The Tribunal was of the view that a registered doctor, who knows he is suspended and is expressly forbidden from prescribing, yet who directly and forcefully asserts to a professional colleague that he is "*entitled to prescribe*" and advises that a prescription be taken elsewhere for dispensing, would be considered by ordinary decent people to have acted dishonestly. His actions were a deliberate attempt to mislead the pharmacist, circumvent the regulatory safeguards protecting the public, and persist in his unauthorised practice. Therefore, the Tribunal concluded that his conduct was dishonest and determined that Paragraph 17 of the Allegation was proved.

The Tribunal's Overall Determination on the Facts

50. The Tribunal has determined the facts as follows:

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

Misconduct

1. On 26 March 2022 you sent an email to Patient A in which you referred to HRT medication as '*smarties*', and in so doing you diminished the importance of the risks and benefits of the treatment. **Admitted and found proved**
2. On 31 March 2022 you issued a private prescription for anti-viral medication for Patient B without:
 - a. An adequate assessment of Patient B; **Admitted and found proved**

- b. obtaining an adequate medical history, including any allergies.
Admitted and found proved
- 3. On 31 March 2022 you issued a private prescription for anti-viral medication for Patient C without:
 - a. An adequate assessment of Patient C; **Determined and found proved**
 - b. obtaining an adequate medical history, including any allergies.
Determined and found proved
- 4. Your action in issuing the prescriptions as set out at paragraphs 2-3 above gave the impression you were a fully registered practitioner with a licence to practice. **Determined and found proved**
- 5. You were not entitled to write the prescriptions in paragraphs 2 and 3 because you:
 - a. did not hold a licence to practise; **Determined and found proved**
 - b. required a licence to practise in order to prescribe. **Determined and found proved**
- 6. When you wrote the prescriptions in paragraphs 2 and 3 you knew;
 - a. that you did not hold a licence to practice **Admitted and found proved**
 - b. that you needed to hold a licence to practice in order to prescribe
Determined and found proved
- 7. Your conduct in paragraphs 2-3 and 4 above was dishonest by reason of paragraphs 5 and 6. **Determined and found proved**
- 8. On 1 April 2022 you sent a text message to Patient D which included the addresses of other Patients and details of appointment dates and times with them, in breach of those Patients' confidentiality. **Admitted and found proved**
- 9. On 2 April 2022 you treated Patient D by injecting her with an HRT implant.
Admitted and found proved

10. You failed to obtain Patient D's fully informed consent to the treatment in paragraph 9 above in that:
- a. treating Patient D as set out at paragraph 9 gave the impression you were a fully registered practitioner with a licence to practise;
Determined and found proved
 - b. you did not inform Patient D that you did not hold a licence to practise;
Determined and found proved
 - c. you did not hold a licence to practise. **Determined and found proved**
11. You wrote and gave to patient D E a private prescription (the prescription) 10mg Vagifem, which you signed and dated 10 November 2022 giving the impression you were a fully registered practitioner with a licence to practise.
Amended under Rule 17(6) Determined and found proved
12. You were not entitled to write or give the prescription to Patient D E because:
Amended under Rule 17(6)
- a. you did not hold a licence to practise; **Determined and found proved**
 - b. you required a licence to practise in order to prescribe; **Determined and found proved**
 - c. your Registration with the General Medical Council had been suspended. **Determined and found proved**
13. When you wrote and gave the prescription to Patient D E you knew that:
Amended under Rule 17(6)
- a. you did not hold a licence to practise; **Determined and found proved**
 - b. you needed to hold a licence to practise in order to prescribe;
Determined and found proved
 - c. your Registration with the General Medical Council had been suspended; **Determined and found proved**

- d. you needed Registration with the General Medical Council.
Determined and found proved
- 14. Your conduct in paragraph 11 was dishonest for the reasons set out in paragraphs 12 and 13. **Determined and found proved**
- 15. On 17 November 2022 the Responsible Pharmacist at Well Pharmacy contacted you about the prescription to confirm, as your registration status had been suspended, the prescription could not be legally dispensed. You told the pharmacist that you:
 - a. were entitled to prescribe; **Admitted and found proved**
 - b. would tell the Patient to take the prescription elsewhere for dispensing. **Admitted and found proved**
- 16. You knew that you were not entitled to prescribe. **Determined and found proved**
- 17. Your conduct in paragraph 15a-b was dishonest for the reason set out in paragraph 16.
Amended under Rule 17(6)
Determined and found proved

Conviction

- 18. **Amended under Rule 17(6)** On 26 March 2024 at Suffolk Magistrates' Court you were convicted of, on 02/04/2022 at Badwell Ash, being a person not holding a licence to practise engaged in conduct calculated to suggest that you had such a licence, in that performing HRT surgery and administering HRT medication to [Patient D] contrary to s.49A(1) Medical Act 1983. **Admitted and found proved**
- 19. **Amended under Rule 17(6)** On 29 November 2024 on your Appeal at the Ipswich Crown Court, you were ordered to pay:
 - a. compensation of £1200; **Admitted and found proved**
 - b. a fine of £180. **Admitted and found proved**

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

a. misconduct in respect of paragraphs 1-16; **To be determined**

b. conviction in respect of paragraphs 17 - 18. **To be determined**

Determination on Impairment - 08/09/2025

51. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved as set out before, Dr Onwude's fitness to practise is impaired by reason of misconduct that is serious or his conviction.

The Evidence

52. The Tribunal has taken into account all of the evidence received during the facts stage of the hearing, both oral and documentary.

Submissions

On behalf of the GMC

53. Mr Kitching submitted that Dr Onwude's fitness to practise is currently impaired. He emphasised that the Tribunal's duty is to assess impairment as of today's date, not merely at the time of the past events in question. The basis for this submission rests on the engagement of all three public interest strands outlined in the Medical Act: the need to protect public safety, to maintain public confidence in the medical profession, and to uphold proper standards of conduct and behaviour.

54. Mr Kitching took the Tribunal through the various paragraphs of the applicable version of *Good Medical Practice (2013)* ('GMP'), namely paragraphs 1, 15(a), 16(a), 16(f), 17, 32, 47, 49, 50, 65, 66, 68 and 77, which he submitted were engaged by Dr Onwude's conduct in this case. He identified dishonesty as the most serious aspect of the case, permeating much of the doctor's conduct. He submitted that Dr Onwude giving patients the impression he was fully registered and licensed was fundamentally dishonest and demonstrated a lack of

integrity. This conduct showed a blatant disregard for the entire regulatory framework, including the licensing, registration, and revalidation regimes that exist principally for patient safety. He submitted that this disregard engaged all three strands of the overarching objective.

55. Regarding the separate clinical allegations, Mr Kitching relied on the expert evidence of Mr G. Mr Kitching invited the Tribunal to consider whether these matters—which include diminishing the seriousness of medication by calling them “*smarties*”, inadequate patient assessment, prescribing without proper assessment, failing to obtain consent, and breaching confidentiality—collectively demonstrated a pattern of behaviour revealing a careless and reckless lack of regard for basic standards. If such a pattern is not found, each allegation must be considered individually for its seriousness. Ultimately, Mr Kitching submitted that the GMC’s position is that all the conduct found proved, both clinical and non-clinical, meets the threshold for misconduct and that the conviction is serious enough to require an impairment finding.

56. On the central question of current impairment, Mr Kitching acknowledged that the Tribunal must consider all relevant information, including the passage of time and, most importantly, the doctor’s demonstration of insight and remediation. He submitted there is a near-complete absence of insight from Dr Onwude concerning the most serious allegations, notably his behaviour after his licence was withdrawn. While some credit was due for his admissions, which displayed insight into the clinical aspects of the Allegation, this was insufficient overall. Mr Kitching submitted that insight and remediation are fundamentally linked to the likelihood of repetition. Given the nature of the conduct—a disregard for the regulatory process and an insistence on operating outside its rules—he submitted that the likelihood of Dr Onwude repeating his conduct was not just high but virtually inevitable. For these reasons, and to uphold the public interest, Mr Kitching submitted that Dr Onwude’s fitness to practise is currently impaired.

Dr Onwude

57. Dr Onwude challenged the legal framework applied by the GMC, arguing that Mr Kitching had fundamentally misstated the overarching objective governing the proceedings. He contended that the 2015 statutory amendments dramatically changed this objective, shifting the priority in fitness to practise procedures—including investigations, hearings, and sanctions—away from the public and onto the doctor himself. He asserted that this new

objective, established by a Regulations Order in Council with statutory power, means that in his specific case, he has become the priority.

58. Dr Onwude criticised the GMC, accusing it of consistently failing to follow its own rules, Regulations, and laws. He specifically challenged the legal validity of the licensing requirement, arguing that the relevant 2002 statutory amendment was overridden and that the 2009 and 2012 Regulations the GMC relies upon are not enforceable in UK courts. He stated that the GMC is attempting to enforce a revoked Regulation and it is confused about the difference between an Act and a Regulation. He added that the GMC did not understand what dishonesty means and accused the GMC of lying. Dr Onwude warned the Tribunal that accepting the GMC's version of events was ‘illiterate’ and would expose its decision to a successful appeal, which he is prepared to pursue.

59. Dr Onwude challenged the evidence of the GMC's expert witness, Mr G, alleging hypocrisy. He claimed that Mr G himself practises medicine without a licence, both in NHS hospitals and privately, and therefore is in no position to criticise him for the same. He stated that he has a duty as a citizen to report this as a crime and indicated that criminal proceedings against Mr G for false representation have already been filed in London, with more cases to follow.

60. On the clinical allegations, Dr Onwude dismissed the criticism of diminishing the seriousness of a medication, asserting his own expert status on the matter and stating his explanations to patients about benefits and risks were sufficient. He similarly dismissed the issue of consent.

61. Regarding his conviction, Dr Onwude invited the Tribunal not to use it as a reason for impairment because the matter is not yet concluded due to his appeal. He alleged that the Judge is delaying the process of giving permission to appeal and that he intends to challenge the Judge's conduct by taking the case to a Magistrates' Court for criminal malfeasance in public office.

62. Dr Onwude concluded by stating that he is retired, no longer wants to practise medicine, and has no patients. He invited the Tribunal to erase him from the medical register, stating it would give him something to do, namely, pursue further legal action. He warned the Tribunal that if they break the law in their decision-making process, he will “*see them in the criminal court*”, referencing past cases involving tribunal members. Dr Onwude informed the Tribunal he would not attend the remainder of the hearing and instructed the Tribunal to do

whatever it wished, stating that his appeal was already prepared and required only a date to be filed.

The Relevant Legal Principles

63. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision of impairment is a matter for the Tribunal's judgement alone.

64. In approaching the decision, the Tribunal was mindful of the two stage process to be adopted: first whether the facts as found proved amounted to misconduct, whether the misconduct (and the conviction) was serious, and then whether the finding of any misconduct and/or conviction could lead to a finding of current impairment.

65. The Tribunal must determine whether Dr Onwude's fitness to practise is impaired today, taking into account Dr Onwude's conduct at the time of the events and any relevant factors since then such as whether the matters are remediable, have been remedied and any likelihood of repetition. The Tribunal considered the issue of misconduct in respect of each issue or type of conduct that had been found proven. Where paragraphs alleged similar conduct to other paragraphs, this similar conduct was considered together but the Tribunal was mindful not to cumulate or aggregate them to reach a finding of misconduct; rather the Tribunal's findings on misconduct are made in relation each and every incidence of conduct.

The Tribunal's Determination on Impairment

66. In reaching its decision the Tribunal reminded itself of the test set out by Dame Janet Smith in *The Fifth Shipman Report*, cited with approval in *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council & Paula Grant* [2011] EWHC 927 (Admin) at paragraph 76:

"Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or

d. has in the past acted dishonestly and/or is liable to act dishonestly in the future.”

Misconduct

67. The Tribunal considered that the following paragraphs of GMP were engaged in this case:

“1 Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.

15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

a adequately assess the patient’s conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient.

16 In providing clinical care you must:

a prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient’s health and are satisfied that the drugs or treatment serve the patient’s needs.

f check that the care or treatment you provide for each patient is compatible with any other treatments the patient is receiving, including (where possible) self-prescribed over-the-counter medications

17 You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research.

32 You must give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.

47 You must treat patients as individuals and respect their dignity and privacy.

49 You must work in partnership with patients, sharing with them the information they will need to make decisions about their care, including:

a their condition, its likely progression and the options for treatment, including associated risks and uncertainties

b the progress of their care, and your role and responsibilities in the team

c who is responsible for each aspect of patient care, and how information is shared within teams and among those who will be providing their care

d any other information patients need if they are asked to agree to be involved in teaching or research.

50 You must treat information about patients as confidential. This includes after a patient has died.

65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.

66 You must always be honest about your experience, qualifications and current role.

68 You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.

77 You must be honest in financial and commercial dealings with patients, employers, insurers and other organisations or individuals."

68. The Tribunal was of the view that all of the above paragraphs of GMP are engaged in this case in the following ways:

- Paragraphs 1, 65, 66, 68 and 77 all speak to being honest, trustworthy and working within legal limits, both with patients and colleagues, as well as being honest in

financial/commercial dealings. Dr Onwude was practising without a licence, and stating to a professional colleague that he was entitled to prescribe, which is the most fundamental breach of these duties.

- Paragraphs 15a, 16a, 16f were applicable to the clinical aspects of assessing patients and prescribing appropriately.
- Paragraphs 17, 32 and 49 related to informed consent. Patient D could not give fully informed consent because Dr Onwude did not provide the crucial information that he was not licensed to perform the procedure.
- Paragraphs 47 and 50 directly addresses the confidentiality breach of sharing other patients' details in a text message.

Paragraph 1

69. The Tribunal found that Dr Onwude's conduct in referring to HRT medication as 'smarties' in an email to Patient A was a significant issue.

70. The Tribunal placed significant weight on the independent expert opinion of Mr G, who stated in the section of his report addressing what conduct fell seriously below the standards expected, that, *“All of the above issues fall outside of the duties of a doctor and thus are considered seriously below the standard expected of any doctor for the reasons stated above. Additionally, he appears to refer to HRT implants as ‘smarties’. Any prescription medication, such as HRT, should be carefully considered and the risks and benefits of treatment weighed by both the doctor in advising treatment, and the patient in deciding on treatment. To refer to medication in such informal and jovial terms diminishes the importance of this consideration.”*

71. The Tribunal agreed with this assessment, emphasising that this was not an isolated incident but was persistent and repeated behaviour. This was evidenced by the email from Patient A herself asking Dr Onwude to stop using the term and confirming she had previously told him to do so. This demonstrated a sustained unprofessionalism that trivialised a significant medical treatment and undermined the necessary careful consideration of its risks and benefits.

72. The Tribunal was of the view that this was misconduct that was serious.

Paragraphs 2 and 3

73. The Tribunal considered Paragraphs 2 and 3 of the Allegation together, as the conduct alleged was identical, albeit for two different patients.

74. The Tribunal considered the issue of whether Dr Onwude's issuing private prescriptions for anti-viral medication to Patients B and C without an adequate assessment or medical history amounted to serious misconduct.

75. The Tribunal had regard to the expert evidence of Mr G, whose report, in the section explaining where aspects of the care were seriously below the standards expected, stated, *"Failing to assess Patients... husband and daughter adequately or at all prior to prescribing antiviral medication. This represents unsafe prescribing, and it is incumbent on any prescriber to obtain a medical history, and a history of any allergies prior to prescription."*

76. The Tribunal agreed with this assessment, concluding that any reasonable doctor would recognise that taking an adequate history and carrying out an adequate patient assessment were fundamental and non-negotiable foundations of safe clinical practice, especially prior to prescribing. It was explicitly noted that while no actual harm was caused to these patients in this instance, the potential for serious harm was significant had an allergy or another contraindication been overlooked. By engaging in this unsafe prescribing, Dr Onwude exposed patients to a foreseeable and avoidable risk.

77. The Tribunal was of the view that this was misconduct that, for each paragraph 2 and 3 independently of each other, was serious.

Paragraphs 4, 5, 9 and 10

78. The Tribunal considered Paragraphs 4, 5, 9 and 10 together, as these related to Dr Onwude practising without a licence by issuing prescriptions and treating Patient D in March/April 2022.

79. The Tribunal assessed whether Dr Onwude's actions in practising without a licence, and giving the impression that he held one, constituted serious misconduct.

80. The Tribunal was of the view that Dr Onwude's behaviour was fundamentally compounded by the direct implications for patient consent.

81. The Tribunal concurred entirely with the expert opinion of Mr G, who stated in his report, in the section on aspects of care that was seriously below the required standard, *"Practicing medicine without a licence, including the prescription, supply and administration of prescription only medication. Doctors are only legally allowed to practice medicine with a licence and he did not hold such a licence."*

82. The Tribunal determined that this breach was a grave violation of the foundational legal and ethical framework governing the medical profession. Crucially, the Tribunal emphasised that by concealing his unlicensed status from his patients, Dr Onwude deliberately deprived them of information vital to providing their fully informed consent. A patient treated without knowledge that the doctor is not legally permitted to practise is, in effect, being treated without their consent, as this deception takes the fundamental choice of who provides their care out of their hands.

83. The Tribunal was of the view that this was misconduct that was serious.

Paragraphs 6 and 7

84. The Tribunal dealt with Paragraphs 6 and 7 together, which related to the dishonesty in writing the prescriptions to Patients B and C when he knew that he needed a licence to practice (which he knew he did not hold) to do so.

85. The Tribunal determined that the element of dishonesty inherent in Dr Onwude's actions profoundly aggravated the seriousness of his misconduct. It was established that his deliberate deception was not a passive omission but an active course of conduct that directly led to him performing a medical procedure on a patient who stated they would not have consented had they been aware of his true status. This demonstrated a clear and consequential betrayal of the patient's trust.

86. Furthermore, the Tribunal noted that this was not an isolated incident of dishonesty given the repetition in November 2022, indicating a pattern of dishonest behaviour. While the Tribunal affirmed that all dishonesty on the part of a doctor is inherently serious, it was mindful that there is a range of dishonest conduct. It concluded that the specific context of this case—where the deceit was employed to systematically circumvent the critical licensing

regime designed to protect the public—made it particularly serious. The deliberate and repeated nature of the conduct, which struck at the very heart of the profession's regulatory framework, marked a severe departure from the standards of integrity expected of a medical practitioner.

87. The Tribunal was of the view that this was misconduct that was serious.

Paragraph 8

88. The Tribunal found that Dr Onwude's disclosure of confidential patient information constituted a serious breach of his fundamental duty to maintain patient confidentiality.

89. The Tribunal agreed with the assessment provided by Mr G in his report, who stated: *“If it is established that the messages contained details of other patients, then to breach their confidentiality would also be seriously below the standard expected of a reasonably competent consultant gynaecologist. Any patient is entitled to confidentiality, and it is Dr JO’s duty to maintain confidentiality. To disclose address details of other patients is in breach of this duty.”*

90. Critically, the Tribunal distinguished this incident from an accidental or inadvertent slip by concluding that the disclosure was a conscious and unnecessary act, simply to save Dr Onwude time in planning a route. This deliberate sharing of sensitive information, including other patients' addresses and appointment details, demonstrated a clear and knowing disregard for the duty of confidentiality that is central to the doctor-patient relationship and a cornerstone of the profession. This conscious violation was deemed a significant failure to uphold the essential standards of trust and professionalism.

91. The Tribunal was of the view that this was seriously below the standards expected and amounted to serious misconduct.

Paragraphs 11 and 12

92. The Tribunal dealt with Paragraphs 11 and 12 together, which related to Dr Onwude writing the November 2022 prescription when he had no licence to practise and he was subject to an interim order of suspension.

93. The Tribunal found that Dr Onwude's actions in writing and issuing a private prescription while his registration was suspended represented an escalation of his previous misconduct and was an aggravating feature, as it showed a disregard for the authority of the Interim Order Tribunal (IOT).

94. While this conduct shared the core serious features of practising without a licence and dishonestly misrepresenting his status as outlined in Paragraphs 4 and 5 of the Allegation, the Tribunal determined that the context of his actions significantly aggravated their seriousness. The crucial aggravating factor was that he engaged in this unlawful prescribing at a time when his registration with the GMC had already been formally suspended. This meant he was not merely operating without a licence but was knowingly defying a direct and explicit order imposed by the IOT, thereby demonstrating a flagrant disregard for the regulatory process itself and showing a conscious determination to continue practising despite being prohibited from doing so. This act represented a direct challenge to the authority of the General Medical Council and the Tribunal.

95. The Tribunal was of the view that this was seriously below the standards expected of a doctor and amounted to serious misconduct.

Paragraphs 13 and 14

96. The Tribunal dealt with Paragraphs 13 and 14 together.

97. The Tribunal found that the dishonesty underlying Dr Onwude's actions in issuing a prescription while suspended was particularly serious, representing a calculated and aggravated repetition of his previous deceptive conduct as detailed in paragraphs 6 and 7.

98. The core elements of dishonesty—actively misleading patients and abusing their trust—remained, but the Tribunal concluded that the context in which these actions occurred markedly increased their gravity. The critical aggravating factor was that this dishonesty was employed to facilitate practising medicine at a time when his registration had been formally suspended. This demonstrated that his deceptive behaviour was not only persistent but was now also deployed in direct defiance of a specific interim order imposed by the IOT.

99. By choosing to act dishonestly in order to circumvent an active suspension, Dr Onwude showed a deliberate and wilful disregard for the entire regulatory framework designed to protect the public, thereby compounding the seriousness of his misconduct.

100. The Tribunal was of the view that this was seriously below the standards expected of a doctor and amounted to serious misconduct.

Paragraphs 15, 16 and 17

101. The Tribunal dealt with Paragraphs 15, 16, and 17 together, as they related to the conversation with Ms F, the pharmacist, on 17 November 2022.

102. The Tribunal found that Dr Onwude's interaction with the responsible pharmacist constituted a particularly serious example of dishonest misconduct due to its targeted nature towards a professional colleague. The Tribunal concluded that this instance of dishonesty was aggravated because it involved another regulated healthcare professional who was diligently carrying out her duty to ensure patient safety and legal compliance.

103. When Ms F, the pharmacist, explicitly challenged him on his suspended registration status, he deliberately asserted that he was entitled to prescribe and suggested that would tell the patient to take the prescription elsewhere, applying pressure on her to either dispense unlawfully or to redirect the problem, thereby attempting to compromise her professional integrity and circumvent the very regulatory safeguards she was upholding. This action demonstrated a willingness to subvert the protective checks and balances within the healthcare system and to draw a colleague into his own wrongdoing.

104. The Tribunal was of the view that this was seriously below the standards expected of a doctor and amounted to serious misconduct.

Paragraphs 18 and 19

105. The Tribunal dealt with Paragraphs 18 and 19 together, as they relate to the conviction.

106. The Tribunal, in considering the criminal conviction, noted the GMC's submissions that the overarching purpose of the licensing regime is the fundamental protection of patients. The Tribunal found that Dr Onwude's conviction for the specific offence of

performing HRT surgery and administering medication while unlicensed, which was calculated to suggest he held a licence, represented a direct and serious breach of this protective framework.

107. The Tribunal was of the view that a conviction for such an offence, which strikes at the very heart of the regulatory structure governing who is permitted to practise medicine, is inherently serious. The fact that this unlawful conduct resulted in a criminal conviction, upheld on appeal, and led to orders for a fine and compensation, further underscored the gravity of the offence in the eyes of the criminal justice system.

108. By engaging in conduct that justified a criminal sanction, Dr Onwude demonstrated a significant departure from the standards of behaviour expected of a registered medical practitioner.

109. The Tribunal was of the view that this conduct that was sufficient to amount to serious misconduct. The Tribunal accordingly found that the threshold for misconduct, which is serious, was met for each and every aspect of the conduct found proved.

Impairment

110. The Tribunal went on to determine whether, as a result of his conviction and/or serious misconduct, Dr Onwude's fitness to practice is currently impaired.

111. While the Tribunal acknowledged that certain aspects of Dr Onwude's misconduct, such as the breaches of confidentiality and consent, might be remediable through targeted courses and learning, it identified the pervasive dishonesty and the continued refusal to accept that the licensing framework applied to him as a significantly more difficult issue to remediate.

112. Critically however, the Tribunal noted a complete absence of any attempt at remediation; despite making some admissions and a partial acknowledgement of wrongdoing, Dr Onwude provided no evidence of having taken any concrete steps towards addressing his failings; he produced no further evidence at the impairment stage.

113. Dr Onwude's insight was assessed as being only partial and limited solely to the specific allegations he admitted concerning Patient B (paragraph 2) and the confidentiality issue (paragraph 8). For the core and most serious elements of his case—the deliberate

practice without a licence and the repeated dishonesty—the Tribunal found no evidence of insight. Instead, Dr Onwude maintained a position of justification for his actions, demonstrating a failure to comprehend the gravity and fundamental wrongness of his conduct. This lack of insight directly informed the Tribunal’s view that the risk of repetition was extremely high, a conclusion underscored by the sustained and continuous nature of his behaviour, which persisted even after his registration had been suspended, showcasing a contemptuous disregard for the regulatory process.

114. The Tribunal applied the framework set out in *Grant* (set out at paragraph 16) and was guided by the overarching objective to protect the public, maintain public confidence in the profession, and uphold proper professional standards and conduct. The Tribunal considered that all four limbs of the test in *Grant* were met in this case, both in respect of past conduct and also on the basis of ‘*being liable in the future*’, due to the high risk of repetition.

115. The Tribunal found that all limbs of the overarching objective were engaged. Firstly, given the high risk of repetition and the serious nature of the dishonesty and unsafe practice, a finding of impairment was necessary to protect the public from future harm. Secondly, given the fundamental breach of trust and the criminal conviction for illegally practising medicine, a finding of no impairment would be insufficient to maintain public confidence in the profession and its regulatory framework. The public would be justifiably concerned if a doctor who deliberately and dishonestly circumvented the licensing regime designed for their protection was not deemed impaired. Finally, his actions represented a severe departure from the standards expected of a doctor, and a finding of impairment was essential to declare and uphold proper professional standards and conduct for the entire profession, sending a clear message that such conduct is unacceptable.

116. The Tribunal concluded therefore, that a finding of impairment was necessary to uphold the three aims of the overarching objective. The Tribunal determined that Dr Onwude’s fitness to practise is currently impaired by reason both of his misconduct and conviction.

Determination on Sanction - 08/09/2025

117. Having determined that Dr Onwude's fitness to practise is impaired by reason of misconduct and his conviction, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

118. The Tribunal has taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

119. Dr Onwude informed the Tribunal that he no longer wished to engage in the proceedings and the Tribunal was satisfied that it was in the interests of justice for the hearing to continue in his absence.

Submissions

On behalf of the GMC

120. Mr Adam Lodge submitted that the only appropriate and proportionate sanction in this case would be one of erasure.

121. Mr Lodge directed the Tribunal to paragraph 20 of the Sanctions Guidance (2024) ('SG') reiterating the importance of proportionality and the necessity of weighing the public interest against the interests of Dr Onwude. He turned to the consideration of mitigating and aggravating factors, reviewing the examples of mitigating factors set out in paragraph 24 of the SG and he submitted that, due to the nature of Dr Onwude's engagement with these and other proceedings, it was difficult to identify any mitigating factors beyond the mere lapse of time since the allegations arose.

122. In contrast, Mr Lodge highlighted the significant aggravating factors detailed from paragraph 50 onwards in the SG, specifically pointing to Dr Onwude's profound lack of insight, as referenced in paragraph 51. He stressed that the Tribunal must give considerable weight to a doctor's insight, or lack thereof, when determining sanction. In support of this, he referred to paragraph 52 of the SG, which indicates that a refusal to apologise or accept mistakes is a clear indicator of a lack of insight. Mr Lodge submitted that there was no apology in this instance and no timely development of insight had been demonstrated. He invited the Tribunal to remember its own determination on impairment, specifically paragraphs 61 to 63, which detailed the most serious elements of the case. He quoted paragraph 63, which stated that the Tribunal had found no evidence of insight and that Dr

Onwude had maintained a position of justification for his actions, demonstrating a failure to comprehend the gravity and fundamental wrongness of his conduct. This lack of insight was noted to have directly informed the Tribunal's view that the risk of repetition was extremely high. Furthermore, Mr Lodge noted Dr Onwude had shown a contemptuous disregard for the regulatory process and invited the Tribunal to take these findings into account when considering sanction.

123. Regarding the specific sanction options, Mr Lodge submitted that, due to the exceptional seriousness of the misconduct found proved—which fundamentally undermines public trust and confidence in the profession—concluding the case by taking no action would be neither proportionate, sufficient, nor in the public interest. He then addressed the option of conditions which require any conditions to be appropriate, proportionate, workable, and measurable. Given the range and seriousness of the misconduct in this case, he argued that an order of conditions would be unworkable. Furthermore, he submitted that the Tribunal could not be satisfied that Dr Onwude would comply with any conditions imposed.

124. On the subject of suspension, Mr Lodge acknowledged that suspension may be appropriate in cases of serious misconduct that are not fundamentally incompatible with continued registration, particularly where there is full insight, remediation and a low risk of repetition. He conceded that, in principle, much of the misconduct in this case might be considered remediable. However, he argued that this was not such a case because there was no acknowledgement of fault; instead, there was an entrenched oppositional attitude and no proper attempt at remediation. He again referenced the Tribunal's prior findings and Dr Onwude's stated belief that he was entitled to practise without a licence and did so whilst subject to an interim order of suspension. Mr Lodge submitted that the required insight and remediation for a sanction of suspension were absent and that the risk of repetition, as previously identified, remained very high.

125. Turning to the option of erasure, Mr Lodge submitted that this was the only means of protecting the public in this case. He argued that Dr Onwude had shown a blatant disregard for the safeguards designed to protect the public and maintain professional standards, which was incompatible with continued registration. He pointed to several factors in paragraph 109 that indicate erasure is appropriate, including particularly serious departures from the principles of GMP, behaviour that is difficult to remediate, dishonesty (which alone is very serious), and an entrenched lack of insight into the seriousness of his actions. Mr Lodge concluded that, on behalf of the GMC, and in accordance with the overarching objective to

protect patient safety, maintain public confidence, and uphold proper professional standards, the only appropriate and proportionate sanction was erasure.

The Tribunal's Approach

126. In reaching its decision the Tribunal took account of the SG and the GMC's statutory overarching objective to protect the public.

127. The Tribunal reminded itself that the main reason for imposing any sanction is to protect the public and that sanctions are not imposed to punish doctors, even though they may have a punitive effect. Throughout its deliberations, the Tribunal applied the principle of proportionality, balancing Dr Onwude's interests with the public interest.

128. The Tribunal took into account the principle set out in the case of *Bolton v Law Society [1994] 1 WLR 512*, that the reputation of the profession is more important than the fortunes of any individual member. The essential issue remained maintaining public confidence in the professions. Matters of personal mitigation, which do not concern the seriousness of the underlying conduct or its impact upon public confidence, are therefore of less weight.

The Tribunal's Determination on Sanction

129. The Tribunal first identified what it considered to be the mitigating and aggravating factors in this case. It was mindful that it needed to consider and balance any such factors against the central aim of sanctions, which is to uphold the overarching objective.

Mitigating Factors

130. The Tribunal considered paragraphs 24-49 of the SG, which sets out some of the mitigating factors that the Tribunal may consider, while balancing these against the central aim of sanctions.

131. The Tribunal agreed with Mr Lodge that it was difficult to identify mitigating factors in this case. It noted that Dr Onwude had admitted some of the paragraphs of the Allegation at the outset of the hearing and bore in mind the lapse of time since the events in respect of the misconduct (which occurred in 2022, the conviction being upheld after appeal in 2024).

Aggravating Factors

132. The Tribunal noted paragraphs 50-59 of the SG, which sets out some of the aggravating factors that are likely to lead a Tribunal to consider more serious action. It was mindful that Dr Onwude is entitled to deny the allegations, but it noted that Dr Onwude had not accepted responsibility for the majority of his actions and inferred that others were to blame for legal misunderstandings.

133. The Tribunal considered the following to be aggravating factors in this case:

- The dishonesty was persistent in that there were three separate instances of dishonesty over an eight month period, involving both patients and a professional colleague (the pharmacist)
- Dr Onwude had not begun any steps towards remediation (even in relation to the limited conduct he had admitted)
- Dr Onwude had not demonstrated any insight into the most serious aspects of the case, namely the dishonesty and practising without a licence and whilst suspended
- Dr Onwude had shown contemptuous disregard for the regulatory framework and these proceedings, including the interim order of suspension.

134. The Tribunal balanced the aggravating and mitigating factors throughout its deliberations and went on to consider each potential sanction in order of ascending severity, starting with the least restrictive.

No action

135. The Tribunal first considered whether to conclude the case by taking no action. It considered paragraphs 68-70 of the SG, which state that taking no action following a finding of impaired fitness to practise is only appropriate in exceptional circumstances.

136. The Tribunal determined that there were no exceptional circumstances present in this case.

137. Additionally, given its findings on impairment, including the high risk of repetition, it determined it would be neither sufficient, proportionate nor in the public interest, to conclude this case by taking no action.

Undertakings

138. No undertakings were considered.

Conditions

139. The Tribunal next considered whether it would be appropriate to impose conditions on Dr Onwude's registration and took into account paragraphs 80 - 84 of the SG.

140. The Tribunal bore in mind that conditions might be most appropriate in cases involving a doctor's health, performance, or lack of knowledge of English and that conditions ought to address the misconduct. Because the misconduct related to acts of dishonesty and practising without a licence, the Tribunal concluded that this was not a case in which conditions are ordinarily appropriate.

141. The Tribunal also bore in mind that any conditions imposed should be appropriate, proportionate, workable, and measurable. It noted that, as set out in paragraph 82 of the SG, conditions may be workable where a doctor has insight into their misconduct, is likely to comply with conditions, and where a doctor is likely to respond positively to remediation or retraining.

142. The Tribunal remained concerned about the lack of remediation to date, and the persistent lack of insight that Dr Onwude had demonstrated. The Tribunal was not satisfied that conditions in these circumstances would be workable or measurable and would not sufficiently address the issues of the case. Given that the Tribunal had found that Dr Onwude had not complied with an interim order of suspension, by issuing the November 2022 prescription whilst suspended, the Tribunal could not be satisfied that he would comply with any conditions imposed.

143. Additionally, the Tribunal considered that conditions would not reflect the seriousness of Dr Onwude's misconduct and would be insufficient to maintain public confidence in the profession and to promote and maintain proper standards of conduct. Therefore, the Tribunal concluded that conditions would not be an appropriate or proportionate sanction.

Suspension

144. The Tribunal then went on to consider whether imposing a period of suspension on Dr Onwude's registration would be sufficient to satisfy the statutory overarching objective.

145. The Tribunal took into account paragraphs 91-98 and 130 of the SG, which assisted the Tribunal in deciding if a period of suspension is the appropriate sanction. It acknowledged that suspension has a deterrent effect and can be used as a signal to the doctor, the profession, and to the public about what is regarded as behaviour unbefitting of a registered doctor.

146. The Tribunal considered the factors listed at paragraphs 97(a)-(g) of the SG, which indicate where suspension may be deemed appropriate. It accepted that there was no evidence of repetition of similar behaviour since November 2022, which is listed as one such factor at paragraph 97(f). The Tribunal could not find any other factors in favour of suspension. For example, there had not been an acknowledgement of fault, it had not found that the misconduct is unlikely to be repeated and there was an ongoing lack of insight. It noted that paragraph 130 of the SG states that where insight is not evident (which is the case here), it is likely that suspension may not be appropriate or sufficient.

147. The Tribunal was mindful that suspension may be appropriate where the conduct is serious but falls short of being fundamentally incompatible with continued registration. The Tribunal had found at the impairment stage that Dr Onwude had breached a number of the paragraphs of GMP, across several domains, and that the four features of the *Grant* case were engaged. Dr Onwude's misconduct brought the profession into disrepute and breached the fundamental tenets of the profession. Dr Onwude had also acted dishonestly on three separate occasions and his actions had the potential to put patients at risk of harm. Due to the very limited insight demonstrated, the Tribunal remained concerned that there was very high risk of repetition.

148. The Tribunal was of the view that a fellow professional would consider Dr Onwude's behaviour, particularly his blatant disregard for the regulatory regime, to be wholly unacceptable. It also concluded that given the seriousness of the misconduct, a member of the public, aware of the full facts of the case, would be concerned if Dr Onwude were allowed to remain on the medical register.

149. The Tribunal determined therefore that Dr Onwude’s conduct was fundamentally incompatible with continued registration and a period of suspension would not be sufficient to maintain the health and safety of patients, to promote and maintain public confidence in the profession, nor promote and maintain proper professional standards and conduct for members of the profession. It decided therefore, that suspension was not sufficient to protect the public and to send a message to the profession and the wider public about the gravity of Dr Onwude’s misconduct.

150. The Tribunal concluded that in such circumstances, to impose a period of suspension, would not uphold the three limbs of the overarching objective.

Erasure

151. The Tribunal therefore went on to consider whether the sanction of erasure was appropriate and proportionate in this case and took into account the guidance at paragraphs 107-111 in the SG. The Tribunal reminded itself again of its findings of fact and the aggravating and mitigating factors it had identified.

152. The Tribunal concluded that Dr Onwude had deliberately departed from a number of the paragraphs of GMP. He had acted dishonestly on three occasions over an eight month period and had gained a criminal conviction. The Tribunal considered paragraph 128 of the SG, which states that dishonesty, if persistent and/or covered up, is likely to lead to erasure. By practising without a licence and whilst suspended, Dr Onwude had prioritised his own interests and he disregarded issues of patient safety and informed consent. The Tribunal had also concluded that Dr Onwude had persistently lacked insight into his behaviour.

153. The Tribunal considered the factors listed at paragraphs 109(a)-(j), of the SG, where erasure may be deemed appropriate. It decided that the following factors were present in Dr Onwude’s case:

a A particularly serious departure from the principles set out in Good medical practice where the behaviour is fundamentally incompatible with being a doctor.

b A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.

d Abuse of position/trust (see Good medical practice, paragraph 81: ‘You must make sure that your conduct justifies your patients’ trust in you and the public’s trust in the profession’).

...

h Dishonesty, especially where persistent and/or covered up...

i putting their own interest before those of their patients.

j Persistent lack of insight into the seriousness of their actions or the consequences.’

154. The Tribunal decided that Dr Onwude’s actions negatively affected confidence in the medical profession. It noted that he had not directly caused harm to any patients, but that his failure to obtain informed consent from patients as well as his lack of adequate patient assessments before prescribing had represented a risk to patient safety. The Tribunal had found that there was a high risk of repetition given Dr Onwude’s entrenched views about the licensing regime. The Tribunal therefore took into account paragraph 108 of the SG, which it considered was applicable. It states:

‘108 Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.’

155. In summary, the Tribunal determined that Dr Onwude had brought the profession into disrepute and undermined public confidence in the profession. He had seriously breached a number of the paragraphs in GMP. Given the lack of insight and remediation, the Tribunal decided that there was a high risk of repetition.

156. The Tribunal decided that erasure is necessary in Dr Onwude’s case to maintain public confidence in the profession and to uphold proper professional standards and conduct for members of the profession. It concluded that a member of the public would be concerned if a sanction of erasure were not imposed in the particular circumstances of Dr Onwude’s misconduct and conviction.

157. In all the circumstances, the Tribunal concluded that Dr Onwude’s interests are outweighed by the need to protect the public, maintain public confidence in the profession and to declare and uphold proper standards of conduct and behaviour.

158. The Tribunal concluded that Dr Onwude’s behaviour was fundamentally incompatible with continued registration and that removal from the register was in the public interest.

159. The Tribunal therefore determined to erase Dr Onwude’s name from the Medical Register.

Determination on Immediate Order - 08/09/2025

160. Having determined to erase Dr Onwude’s name from the Medical Register, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Onwude’s registration should be subject to an immediate order.

Submissions

On behalf of the GMC

161. Mr Lodge submitted that given the seriousness of the misconduct found and on the basis of potential impact to public confidence, an immediate order is in the public interest, and it will be appropriate for Dr Onwude to not to continue in unrestricted practice before the substantive order takes effect.

The Tribunal’s Determination

162. The Tribunal had regard to the submissions made by Mr Lodge and to the guidance contained within the SG, in particular, paragraphs 172, 173 and 178 which state:

“172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor,

which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.

173 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.

...

178 Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect."

163. The Tribunal bore in mind the above paragraphs of the SG and took account of its findings at earlier stages. It reminded itself that as Dr Onwude previously disregarded his interim order of suspension and continued to prescribe and practise without a licence to practise, he remained a risk to the public. The Tribunal considered the high risk of repetition as well as the seriousness of the matter that led to Dr Onwude's erasure and determined that an immediate order of suspension is necessary to protect members of the public, to uphold confidence in the medical profession and is in the wider public interest.

164. This means that Dr Onwude's registration will be suspended from the date on which notification of this decision is deemed to have been served upon him. The substantive direction, as already announced, will take effect 28 days from that date, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

165. The interim order will be revoked when the immediate order takes effect.

166. That concludes this case.

ANNEX A - 08/09/2025

Application under Rule 17(2)g

167. Following the close of the GMC's case, Dr Onwude made an application pursuant to Rule 17(2)(g) the Rules of 'no case to answer'. Whilst Dr Onwude did not specify the particular paragraphs of the Allegation that in his submission should proceed no further, the Tribunal considered the application in relation to paragraphs 1, 3, 4, 5, 6(b), 7, 10, 11, 12, 13, 14, 15, 16 and 17 of the Allegation.

168. Rule 17(2)g provides that:

'17(2) The order of proceedings at the hearing before a Medical Practitioners Tribunal shall be as follows—

...

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

169. Dr Onwude submitted that the GMC had adduced insufficient evidence to prove the allegations, and he invited the Tribunal to decide that the disputed paragraphs of the Allegation should go no further.

170. Both parties provided written submissions in relation to the application and made oral submissions to the Tribunal. Below is a summary of the parties' written and oral submissions, taken together, and is not intended to be exhaustive.

Dr Onwude's submissions

171. Dr Joseph Onwude submitted that there is no case for him to answer, arguing that the GMC's case is fundamentally flawed on both factual and legal grounds. His submissions were centred around two primary contentions: that the allegations are incorrectly specified and based on a false premise, and that the legal requirement for a Licence to Practise, upon which the entire case hinges, was revoked and no longer exists in law.

172. Despite having admitted it at the outset of the hearing, Dr Onwude made submissions relating to Paragraph 1 of the Allegation, which concerns referring to HRT medication as "smarties." He asserted this accusation is both "wrongly specified" and a "false accusation." He submitted that the patient in question was receiving Estrogen Replacement Therapy (ERT), not Hormone Replacement Therapy (HRT), as she did not have a womb. He argues that referring to ERT implants as "smarties" cannot diminish the risks and benefits of HRT, as they are different treatments. Additionally, he stated that he was entitled to refer to these treatments as "smarties" to his patients due to his expertise in relation to them. To substantiate this, Dr Onwude positioned himself as a world expert on the subject, citing his own publications on HRT versus ERT and claiming that the GMC's expert witness has no published expertise in this specific area. He submitted that the GMC's allegation is unfounded and cannot be proved.

173. Dr Onwude submitted that the requirement for a Licence to Practise had been abolished. He outlined a legislative history, stating that the 2002 and 2009 Regulations which established the need for a licence were revoked by the 2012 Regulations (the GMC (Licence to Practise and Revalidation) Regulations Order of Council 2012). He submitted that, as a result, "a doctor on the Medical Register does not require a licence to practice as it no longer exists." He said that "Regulations are different from the law and are no enforceable". Consequently, he argued that the Tribunal has no legal basis to continue the hearing, as the GMC itself withdrew the very requirement that underpins the allegations against him. He further challenged the physical existence of a licence, questioning whether it exists as a tangible document or certificate with an identifying number, suggesting that the entire concept is used unlawfully by the GMC.

174. Dr Onwude referenced his criminal conviction under Section 49A of the Medical Act 1983. He submitted that his conviction is currently under appeal to the Court of Appeal and that this should preclude the Tribunal from continuing to hear this case until his appeal in the criminal matter is fully disposed of. He submitted that a "no case to answer" submission is warranted because a key element of the offence—"pretending"—cannot be proven. He relied on the CPS Opening Statement from his appeal, which stated that the complainant (Patient D) "was aware that the Appellant's license to practice medicine had been revoked by the GMC previously". He argued it was "illogical and implausible" that he would need to pretend to hold a licence to someone who already knew he did not have one, thus defeating the essential basis of the charge.

175. Dr Onwude criticised the evidence presented by the GMC, particularly that of Mr H (Investigation Officer at the GMC). He accused Mr H of giving "misleading evidence" by consistently using the word "revoked" instead of the legally accurate "withdrawn" in relation to his licence, a distinction he claimed is both semantically and legally significant. He further alleges that Mr H's witness statements, endorsed by a Statement of Truth, are procedurally defective under CPR Part 22 and amount to "Fraud by False Representation" under the Fraud Act 2006. He supported this accusation by citing a Court of Appeal case (*Liverpool Victoria Insurance Co Ltd v Zafar*) to illustrate the consequences for making a false statement verified by a statement of truth. He also dismissed the GMC expert's evidence as "useless" and claimed he waived his right to cross-examine Patient D because her prior knowledge of his licence status, as stated by the CPS, was already on record and concretely defeated the GMC's case.

176. Dr Onwude applied the legal test from *R v Galbraith*, arguing that the submission of "no case to answer" should be upheld. He invoked both limbs of the test: firstly, that there is no evidence upon which a Tribunal could convict because the core legal requirement (a licence) did not exist and the element of "pretending" is implausible given the complainant's knowledge; and secondly, that the evidence which has been presented is "so poor" and has been so "discredited" that it would be unsafe to convict. He characterised the GMC's evidence as showing "evidential emptiness," citing witnesses who claimed not to remember details despite signing Statements of Truth.

177. Dr Onwude asserted that the GMC's actions against him have been unlawful. He argues that the withdrawal of his licence in 2021 was based on the revoked 2009 Regulations, not the 2012 Regulations in force at the time. He highlighted a contradiction that he believes undermines the GMC's entire case: while they withdrew his licence for a failure to revalidate, they later admitted in court that he had, in fact, successfully revalidated in 2020. He suggested that this case raised fundamental legal questions about the GMC's regulatory framework that may require senior court intervention to resolve, maintaining that he cannot be guilty of breaching a requirement that was not legally in force.

GMC submissions

178. On behalf of the GMC, Mr Kitching submitted that the Tribunal should refuse the application.

179. Mr Kitching outlined that the test of *R v Galbraith* dictated that if there is no evidence, the case must be stopped. He acknowledged that difficulty arises where evidence exists but is of a tenuous character due to inherent weakness, vagueness, or inconsistency. He submitted that the Tribunal must take the prosecution evidence at its highest; if, when viewed this way, a properly directed Tribunal could not properly find a charge proved, it is their duty to stop the case. Conversely, if the evidence's strength depends on the view taken of a witness's reliability or other matters within the Tribunal's province, and where on one possible view of the facts there is evidence upon which a Tribunal could properly conclude the doctor is guilty, the case should proceed. This principle was further considered in *R v Shippey*, which clarified that taking the prosecution case at its highest does not mean selectively picking out strong points while ignoring weak, contradictory, or nonsensical evidence. If the evidence upon which the prosecution case depends is self-contradictory and "out of reason and all common sense," it is tenuous and suffers from inherent weakness. Mr Kitching emphasised that this test requires a low evidential bar; the Tribunal need only ask if there is evidence upon which they *could* find an allegation proved, not whether they already do so.

180. In response to Dr Onwude's challenge to Paragraph 1 of the Allegation, Mr Kitching submitted that his argument, which is based on a purported distinction between estrogen-only therapy (ERT) and combined hormone replacement therapy (HRT), was without merit. The GMC's expert, Mr G, in his report referenced an email from Dr Onwude where he referred to HRT implants as "smarties," and the recipient patient explicitly asked him to stop using that term for HRT medication. Mr G drew no such distinction between types of HRT in his analysis, and Dr Onwude's claim that estrogen-only treatment cannot be described as HRT was not put to the expert during his testimony. Mr Kitching contended that it was clear from the report that describing estrogen-only treatment as HRT is not inaccurate, and there is certainly evidence upon which the Tribunal could find the allegation proved, with no oral evidence from Dr Onwude yet to contradict this.

181. Mr Kitching addressed Dr Onwude's submissions regarding the legal requirement for a Licence to Practise. Dr Onwude suggested the requirement was revoked when the 2009 Regulations were replaced by the 2012 Regulations which was incorrect. Mr Kitching clarified that the statutory provisions for registration are under Sections 2 and 3 of the Medical Act 1983, while those for licensing are under Part IIIA. The 2012 Regulations, which were in force and have not been revoked, are valid secondary legislation with the force of law, not mere "statutory guidance" as Dr Onwude claimed. Their key difference from the 2009 Regulations was placing revalidation on a statutory footing.

182. Mr Kitching emphasised that to "practise medicine" a doctor must hold both Registration and a Licence to Practise. What constitutes the "practice of medicine" is a question of fact for the Tribunal. However, Mr Kitching submitted that the procedure to insert an HRT pellet constitutes "treatment" (which Dr Onwude has admitted), and the prescribing of prescription-only medications (POMs) to treat a patient are clear examples of practising medicine. While the Human Medicines Regulations 2012 define a "doctor" exempt from supply restrictions as a "registered medical practitioner" without explicit mention of a licence, Mr Kitching submitted that prescribing to treat is a core part of practising medicine and therefore requires a licence. Mr Kitching invited the Tribunal to take a purposive approach to the legislation, interpreting it in a way that best achieves the overarching objective of the Medical Act: the protection of the public.

183. Mr Kitching cited GMC guidance, which explicitly states that a licence is required to "practise medicine in the UK" and to carry out activities "such as prescribing medicines." It further lists writing prescriptions as a privilege for which a licence is required. Historical written evidence from the GMC to the House of Commons Health Committee prior to the 2009 licensing introduction is also referenced, which stated doctors would need a licence if they "want to write prescriptions." Mr Kitching submitted that Dr Onwude's licence was withdrawn on 13 July 2021 and his registration was subsequently suspended on 10 August 2022. Upon suspension, Section 41A(11) of the Medical Act states he is to be treated as not being registered, notwithstanding that his name still appears on the register.

184. Mr Kitching described several other points raised by Dr Onwude as lacking merit. He described Dr Onwude's suggestion that a licence does not exist because it is electronic and not a paper document as lacking common sense. The claim that there is a meaningful difference between the "withdrawal" and "revocation" of his licence is also rejected; the contemporaneous documentation shows it was withdrawn, and the effect—that he did not have a licence—is what matters. Furthermore, Mr Kitchen deemed Dr Onwude's challenge to the legitimacy of the 2021 withdrawal of his licence for failing to submit an annual return was irrelevant for this Tribunal, as he had a right of appeal which he did not exercise, and his licence was never restored.

185. Regarding his criminal conviction for pretending to hold a licence, Mr Kitching stated that Dr Onwude's appeal to the Crown Court was refused. Any further potential appeal does not preclude the Tribunal from relying on the conviction, which is conclusive proof of guilt under Rule 34(2) of the Fitness to Practise Rules. Mr Kitching addressed Dr Onwude's reliance on a CPS opening statement that claimed Patient D knew he had lost his licence. He stated

that this was a misrepresentation of her police statement, which referred to earlier “GMC problems” that she was aware Dr Onwude had faced, not her knowledge of his licence status in April 2022. Patient D had clarified in her evidence before this Tribunal that she did not know his licence status in April 2022.

186. Concerning the prescriptions, Mr Kitching outlined there is evidence which shows three were issued on 31 March 2022 for Patients B, C and D. The prescription for Patient D (Vagifem) was presented the following week and refused by a pharmacist because Dr Onwude had no licence. A fourth, anonymised prescription for Vagifem was dated 10 November 2022. Patient D testified she received no prescriptions after 31 March 2022 and did not present the November prescription, confirming it was for another patient. For the prescription issued to Patient C, Dr Onwude’s provided medical records were for a different individual, leaving Mr G’s critical opinion unchallenged.

187. Mr Kitching argued that issuing a prescription inherently gives the impression the doctor is licensed to do so, which forms the basis for allegations of dishonesty. He submitted that there is ample evidence from which the Tribunal could infer Dr Onwude knew he needed a licence, given he was “intimately aware” given his involvement with the GMC in 2021 and the clear guidance available. Mr Kitching reminded the Tribunal that the test for dishonesty requires establishing Dr Onwude’s subjective knowledge and then judging his conduct by the objective standards of ordinary decent people.

188. For the allegation concerning a lack of fully informed consent, Mr Kitching submitted that the facts determined in the criminal proceedings (that Dr Onwude misled Patient D about his status) cannot be re-opened. Patient D’s clear witness statement that she would not have consented to treatment had she known he was unlicensed supports the conclusion that her consent was not fully informed.

189. Finally, regarding the November 2022 prescription, Mr Kitching contended a strong inference exists that it was written on the date it bears (10/11/22), after Dr Onwude’s registration suspension. This was supported by the pharmacist Ms F’s account of her conversation with Dr Onwude, in which he asserted his current entitlement to prescribe and made no claim that it was a post-dated prescription. Mr Kitching submitted that Dr Onwude’s defence was not that he was entitled to prescribe in November but that he did not do so, an assertion the GMC rejects. Mr Kitching submitted that if the Tribunal finds Dr Onwude knew he was not entitled to prescribe at that time, then his assertions to the contrary to Ms F were dishonest.

The Tribunal's Approach

190. The Tribunal reminded itself that, at this stage, its purpose was not to make findings of fact but to determine whether sufficient evidence, taken at its highest, had been presented by the GMC such that a properly directed Tribunal could find the relevant paragraphs proved to the civil standard. The Tribunal considered the written and oral submissions made by both parties and had regard to all the evidence adduced by the GMC.

191. In considering whether sufficient evidence had been adduced to find these paragraphs of the Allegation proved, the Tribunal had regard to test as set out in *R v Galbraith [1981] 2 All ER 1060*, which is applicable also to these proceedings:

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

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

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

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

The Tribunal's Decision

192. In reaching this decision, the Tribunal methodically addressed each of Dr Onwude's key arguments, considered against each paragraph of the Allegation that remains in dispute.

193. Regarding the "smarties" allegation (paragraph 1 of the Allegation), while noting it had already been found proved based on Dr Onwude's admission, the Tribunal nevertheless considered his new argument distinguishing between Hormone Replacement Therapy (HRT) and Estrogen Replacement Therapy (ERT). It concluded this was a distinction without a material difference, considering that HRT is essentially an umbrella term. It noted that National Institute for Clinical Excellence (NICE) guidance classifies oestrogen-only treatment as a form of HRT and that both have the same status as prescription-only medications as per the British National Formulary (BNF). The Tribunal was of the view that this point did not alter the substance of what was alleged, which was that by referring to the treatment as "smarties" this diminished the importance of the risks and benefits of the treatment. The Tribunal was satisfied that, applying the Galbraith test, a reasonable tribunal could find this paragraph of the Allegation proved on the evidence before it.

194. Concerning Dr Onwude's arguments regarding the validity of the licensing regime (paragraphs 5 and 6), the Tribunal was of the view that Dr Onwude's core legal argument that the requirement for a Licence to Practise was revoked, under the 2012 Regulations, was unfounded and without merit. It found that a reasonable tribunal could conclude that his interpretation of the Regulations was erroneous and that a robust licensing framework remains in effect. The Tribunal also considered a reasonable tribunal could conclude that Dr Onwude's point about not possessing a physical licence to be irrelevant, as there has never been any requirement for doctors to be provided with a physical copy of the licence.

195. The Tribunal considered Dr Onwude's submissions relating to the difference in meaning between the words "revoked" and "withdrawn". On the specific use of the word "revoked", which had been referred to by Mr H in his statement requested by the police, versus "withdrawn", which had been used in the GMC correspondence, the Tribunal saw no material difference in effect or meaning between the two terms and noted that the key document of the Assistant Registrar's decision, dated 3 June 2021, used the correct terminology under the Regulations of "withdrawn". The Tribunal was of the view that Mr H later using a different but similar word in a police statement to describe what had occurred had no effect and did not change the Assistant Registrar's earlier decision.

196. On the related issue of prescribing, the Tribunal considered that it had before it sufficient evidence that a reasonable tribunal could find Dr Onwude knew he needed a licence to do so, in light of the detailed correspondence and GMC guidance that he had received which clearly stated he must not practise medicine without one.

197. For the prescription issued to Patient C (paragraph 3), the Tribunal noted that the clinical records Dr Onwude had provided, which he had suggested were for Patient C to support his assertion that he had treated her previously, appeared to be for a different individual (based upon different ages and dates of birth), and therefore, on the evidence currently before it, taking the GMC's case at its highest, there was sufficient evidence to proceed.

198. For the allegations concerning whether Dr Onwude's actions in March 2022 gave the impression that he was a fully registered medical practitioner with a licence to practice (paragraph 4) and the linked allegation regarding lack of consent (paragraph 10), the Tribunal noted the evidence of Patient D herself—who stated she would not have consented to nor have proceeded with the treatment had she known that Dr Onwude did not hold a licence to practice. The Tribunal considered Dr Onwude's submissions regarding the CPS opening statement document, which he relied upon to submit that Patient D did know that he did not hold a licence. The Tribunal did not consider that this document undermined the evidence of Patient D and considered that it was of limited evidential value as it was a lawyer's submission from separate proceedings. Furthermore, it did not fully capture what Patient D had stated in her police statement, which was that she had been aware of previous issues that Dr Onwude had in 2014-2016, which were then resolved. In view of Patient D's clear evidence of her understanding of Dr Onwude's licence position as at March 2022 (which was that he had one) the Tribunal was satisfied that there was sufficient evidence upon which this could be found proved.

199. Regarding the November 2022 prescription for Patient E (allegations 11, 12 and 13) the Tribunal considered that there was sufficient evidence from both Patient D, Ms F and the copies of the various prescriptions themselves, that a reasonable Tribunal could find that the prescription was for a different individual and, given the date on the face of the prescription, to infer that it was presented after Dr Onwude's registration had been suspended.

200. The Tribunal considered the submissions made by Dr Onwude regarding his criminal conviction. The Tribunal was mindful that under Rule 34, the certificate of conviction is conclusive evidence and that the effect of this is that the conviction remains fully valid until and unless any further appeal is successful. The Tribunal was not persuaded by Dr Onwude's submission that it ought to stop hearing this case until that appeal was concluded.

201. On the allegations of dishonesty (allegations 7, 14, 16 and 17), the Tribunal was satisfied that on the evidence before it at this stage there was a case for Dr Onwude to

answer, as a reasonable Tribunal could find that Dr Onwude knew he was not entitled to practise or prescribe and that his actions in asserting otherwise (including stating that he was entitled to prescribe to a pharmacist) could properly be found to be dishonest, when applying the test for dishonesty.

202. The Tribunal, having considered Dr Onwude's application under Rule 17(2)(g) in respect of each disputed part of the Allegation, determined to reject it in its entirety, finding that there was a case to answer for each and every outstanding paragraph of the Allegation.