Neutral Citation Number: [2021] EWHC 539 (Admin)

Case No: CO/1179/2020

**IN THE HIGH COURT OF JUSTICE**
**QUEEN'S BENCH DIVISION**
**ADMINISTRATIVE COURT**

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 9 March 2021

**Before** :

**MR JUSTICE JOHNSON**

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**Between :**

MR GIULIO GARAFFA

**Appellant**

**- and -**

THE GENERAL MEDICAL COUNCIL

**Respondent**

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Martin Forde QC (instructed by CMS Cameron McKenna Nabarro Olswang LLP) for the Appellant
Alexis Hearnden (instructed by GMC Legal) for the Respondent

Hearing dates: 23 – 24 February 2021

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# Approved Judgment

## Mr Justice Johnson:

1. The Appellant, a consultant urological surgeon, carried out a vaginectomy (removal of the vagina) on a patient ("Patient A") without his consent. A Medical Practitioners Tribunal ("MPT") found that the Appellant's fitness to practise was thereby impaired on account of misconduct. It decided that his name should be suspended from the medical register for a period of 5 months. The Appellant appeals against his suspension. He advances 15 separate grounds of appeal. He challenges the MPT's underlying findings of fact, misconduct and impairment, and the sanction that it imposed.

2. It is (now) common ground that: (1) Patient A did not consent to a vaginectomy, (2) the consent form that Patient A signed did not have any reference to a vaginectomy, and (3) a copy of the consent form was dishonestly amended by the Appellant's assistant, Dr Capece, to include reference to a vaginectomy. The MPT found that this amendment was made after the surgery commenced. It had not therefore been made before the pre-operation checks were carried out, so the consent form that was read out during those checks did not include a reference to a vaginectomy. The Appellant contends that finding was wrong and that, on the evidence, the MPT should have found that the amendment was made before the surgery commenced. He says that his conduct did not fall so far below the required professional standard as to amount to misconduct, that he has remedied his conduct (because he now personally conducts the consent process with his patients) such that there is no continuing impairment, and that the sanction imposed was disproportionate and wrong in principle.

## Factual background

3. The surgical procedures: Three surgical procedures were carried out on Patient A on 29 October 2016:

   (1) A laparoscopic total abdominal hysterectomy with bilateral salpingo-oophorectomy ("TAHBSO"): This involves the removal of the uterus, cervix, fallopian tubes and ovaries. It was carried out by laparoscope. This procedure (about which no complaint is made) was carried out by Miss Kokka, a consultant gynaecologist, and the Appellant was not directly involved. Miss Kokka was not involved in (2) and (3) below.

   (2) A metoidioplasty: This involves the formation of a new penis using the tissue of the clitoris. The labia are sutured together to form a neo-urethra that reaches the tip of the penis so that the patient can void urine in a standing position via the tip of the neo-penis. This procedure (about which no complaint is made) was carried out by the Appellant.

   (3) A vaginectomy: This involves ablating the vaginal wall with high energy diathermy followed by its obliteration. The procedure lasts 20-30 minutes. It is irreversible. In the context of gender reassignment surgery, a vaginectomy is an elective procedure. It can be performed at any time, either alongside a metoidioplasty or separately. Complications are less likely if a vaginectomy is performed at the same time as a metoidioplasty (as opposed to subsequently) and the majority of patients who undergo metoidioplasty choose to have a vaginectomy. This procedure was carried out by the Appellant.

4. The sequence of events: Patient A's identity is not relevant to any issue and it has not been revealed within these proceedings. His gender at birth was female. From early childhood there was a history of cross-gender identification. In 2013 (when Patient A's age was in the range 25-35) he changed his name and began living as a man. He was referred by his general practitioner to a gender identity clinic. He underwent assessment and psychotherapy. In 2014 he commenced hormone therapy. In June 2014 a consultant psychiatrist/gender identity expert recommended chest surgery and sex reassignment surgery. Reconstructive chest surgery was undertaken later that year. In 2015 it was confirmed that he was suitable for onward assessment for sex reassignment surgery. A letter between clinicians accurately confirms that he had decided to have a hysterectomy and metoidioplasty. At that stage he was undecided as to whether he wished to undergo a vaginectomy. He was advised that he had plenty of time to make a decision, and that he could do so after the first stage of the surgery.

5. Patient A underwent the first stage of the metoidioplasty in early 2016. By the time of the follow up appointment he had decided that he did not wish to undergo a vaginectomy, and he made this clear. Correspondence between clinicians which are within Patient A's medical records clearly record this decision. In August 2016 Patient A was told that the hysterectomy and the second stage of the metoidioplasty would be carried out on 29 October 2016 at Highgate Hospital. A hospital admission booking form was generated in September 2016. This recorded the procedure as being "complete metoidioplasty and Lap[arscopic] TAHBSO vaginectomy…" The reference to "vaginectomy" was an error for which the Appellant bears no responsibility.

6. On the evening of 28 October 2016 Patient A was admitted to Highgate Hospital. He was not, at any stage before being anaesthetised, seen by the Appellant. He was seen on the evening of 28 October by Dr Capece. A consent form was completed for the metoidioplasty. There was no mention of a vaginectomy.

7. At some time between 8am and 8.30am on 29 October 2016 Patient A was seen by Miss Kokka, the consultant gynaecologist who was to perform the TAHBSO. She secured Patient A's consent for the TAHBSO. This was recorded on the consent form. Patient A was then provided with a carbon copy of the consent form. The top copy was retained in Patient A's notes. At this point there was no reference to a vaginectomy on either copy of the consent form.

8. The Appellant attended a team meeting ahead of the surgery. This commenced at 8.30am. The theatre list was consistent with the booking form and recorded (wrongly) that Patient A was to undergo a vaginectomy. The consent form and medical notes were not available at that point, so there was nothing in the documentation available at the team meeting to contraindicate that which was recorded in the theatre list.

9. Patient A was taken by Nurse Stevenson to the operating theatre. A World Health Organisation ("WHO") checklist was completed before the surgery commenced. It was undertaken in three stages. The first stage, "sign in", was completed before anaesthesia was administered. This part of the checklist was completed to show (amongst other things) that a team briefing had taken place, and that the patient had confirmed "consent" (without separately recording in the form what had been consented to). The second stage, "time out", was completed after anaesthesia had been administered. This part of the checklist was completed to show (amongst other things) that the surgeon, anaesthetist and registered practitioner had verbally confirmed the "procedure planned"

(without separately recording on the form what that procedure was to be). The third stage "sign out" was completed following the surgery.

10. An amendment was made to the consent form to record that the TAHBSO would be carried out by laparoscope. Miss Kokka confirmed that she made this amendment by way of clarification. Miss Kokka performed the TAHBSO. The Appellant then performed the metoidioplasty and the vaginectomy. At some point after the two copies of the consent form had been separated, the top copy of the consent form was amended by Dr Capece to add "+ vaginectomy". A significant issue for the FTTP to resolve was when this occurred.

11. The outcome for Patient A is irreversible. Although many patients choose to undergo vaginectomy at the same time as metoidioplasty, Patient A made a clear careful and informed decision that he did not wish to do so. He sets out in his statement, which was adopted in the evidence he gave before the MPT, a detailed account of the profound psychological effect that this has had on him.

12. The Appellant's professional background: The Appellant obtained his primary medical qualification from the University of Trieste, Italy in 2001. He received the equivalent of the Fellowship of the Royal College of Surgeons (FRCS) as a specialist in Urology from the University of Trieste in 2006. In 2015 he obtained a PhD from the University of La Sapienza, Rome.

13. The Appellant has practised urology in the United Kingdom since March 2005. This included locum consultant appointments between April 2001 and September 2001. He has a special interest in andrology and reconstruction surgery. He was appointed a consultant urological surgeon with a special interest in andrology and reconstructive surgery and an honorary lecturer in urology at the University College London Hospitals where he remains in post. He has published and lectured in andrology and reconstruction surgery widely throughout Europe and elsewhere in the world.

14. From 2006 the Appellant has had a special interest in gender reassignment surgery. In October 2016 the Appellant was performing gender reassignment surgery for the St Peter's Andrology Centre, London, an independent urology service which specialises in gender reassignment surgery, providing services to the National Health Service. He initially started working at the St Peter's Andrology Centre in 2007 as a clinical fellow in order to develop his expertise in andrology. Following his appointment as consultant, he worked as an independent contractor at St Peter's Andrology Centre until October 2017.

15. Twelve testimonial letters from the Appellant's professional colleagues were placed before the MPT. The authors had, between them, known and worked with the Appellant over his entire professional career. They spoke to the Appellant's skill as a surgeon ("one of the top andrological surgeons in the UK"; "one of very few surgeons worldwide who fully master the procedure of gender reassignment and he has done hundreds of these cases"), teacher and researcher. They also testified that "his interaction with patients [was] excellent", he "always put his patient first", his decision-making "was always centred on patient safety and best care", he had "always been able to recognize his limitations and seek help accordingly", he was "meticulous and honest with his patients", he "would put patient care as his top priority and go the extra mile to tend to a patient", he had "patients' interests at heart", he was "so humble", he did

not "cut corners", and that he was "meticulous in carrying out [the consenting of patients]".

## Evidence and MPT findings

*The time at which, and the circumstances in which, the consent form was amended*

16. Dr Capece accepted that he made the change to the consent form to add "+ vaginectomy". He said that he had noticed the discrepancy between the booking form (which referred to a vaginectomy) and the consent form (which did not), and that he clarified this with Patient A on 29 October, in advance of the surgery, and amended the consent form accordingly. His case, therefore, was that Patient A had been properly and positively consented for a vaginectomy. The Appellant supported Dr Capece's account (albeit he had not directly witnessed the change to the form). He says that he had asked Dr Capece to double check with Patient A that he wished to undergo both a metoidioplasty and vaginectomy and that Dr Capece (after checking) confirmed that this was correct. The MPT also heard evidence from Patient A who was adamant that he had not wanted to have a vaginectomy and that he had not provided the consent that was recorded by Dr Capece.

17. The MPT heard evidence from those who had been present during the surgical checklist procedures. The Appellant and Dr Capece maintained that the consent form did include "vaginectomy" at this point. Unsurprisingly, no other witness claimed to have a recollection of precisely what had been read out from the consent form, and in particular whether "+ vaginectomy" was, or was not, read out. The witnesses were therefore giving evidence on the basis of whether they would have noticed if "vaginectomy" had been omitted:

    (1) Miss Kokka, the consultant gynaecologist (who was not involved in the metoidioplasty or vaginectomy) said that she would have "expected" this to have been noticed, but not by her ("I would not expect me to notice that to be honest").

    (2) Dr Ahmed, the anaesthetist, was certain that "vaginectomy" had been said, but this was on the basis that nobody had raised a concern, rather than a positive recollection of what was in fact said. His evidence was that this was not within his remit, and he did not suggest that he would have noticed the discrepancy.

    (3) Dr Chiriaco had no recollection of the matter and said he "never checked the [check]list, it was done by someone else."

    (4) Mr Rich said he would have ensured that the Appellant was present when the checklist was completed. So far as Mr Rich was concerned, however, he would not have registered the absence of "vaginectomy" from the consent form because he was under the misapprehension that a metoidioplasty necessarily included a vaginectomy.

    (5) Nurse Stevenson (who was responsible for signing the checklist to show it had been completed) did not know whether a metoidioplasty included a vaginectomy, and did not suggest that she would have noted the absence of the word "vaginectomy" from the consent form.

(6) A prosthetics coordinator did not suggest that she would have noticed – she said she was not focussed on the consent procedure.

18. The MPT considered that two issues were central to its resolution of the case, namely whether Patient A had consented to the vaginectomy, and whether, when and in what circumstances "+ vaginectomy" was entered on the consent form.

19. As to the first of these issues, the MPT found that Patient A did not consent to a vaginectomy. Having heard evidence from Patient A it found that if this had been mentioned to him then he would have made his opposition to the procedure quite clear. It therefore rejected the account that was given by Dr Capece. There is (now) no challenge to that finding. The MPT also rejected the Appellant's account that he had told Dr Capece to "double check" the position. It found that the Appellant's account was "vague and unconvincing", that he did not have any "specific recall" of the events, that there would not, on the Appellant's account, have been any reason for him to tell Dr Capece to "double check", and that the Appellant had not given any satisfactory explanation for doing so. Moreover, the Appellant's account that he had asked for this "double check" was only given some considerable time after Patient A's initial complaint was made, and only after the discrepancy between the consent forms came to light. The Appellant's initial response when the complaint was first made did not make any reference to this "double check". The MPT considered that if there had been a double check then it is likely that the Appellant would have recalled this at the time of the complaint, and that it is unlikely that he would have recalled it for the first time many months thereafter. For the same reasons, the MPT considered that the Appellant could not have reviewed Patient A's notes as he had claimed to have done, because he then would have been alerted to the discrepancy between the notes (which made it clear Patient A did not wish to have a vaginectomy) and the theatre list, and he would have recalled this when the complaint was made.

20. As to the amendment to the consent form, the MPT was entirely satisfied that this took place after Patient A had been anaesthetised and without Patient A's knowledge and in circumstances where Dr Capece knew that Patient A had not consented to the procedure. It considered that the amendment was made dishonestly, either because Dr Capece had appreciated that the surgical team had performed a vaginectomy without consent, or because Dr Capece assumed that he had made an error by failing to discuss a vaginectomy with Patient A. The MPT considered that there would have been no reason for Dr Capece to amend the form before the surgery commenced.

21. It was argued on the Appellant's behalf that the word "vaginectomy" must have been included on the consent form by the time of the "time out" procedure, because a member of the surgical team would otherwise have been bound to note the discrepancy, and because the addition of the word "laparoscopy" (see paragraph 10 above) showed that the team were engaged in, and attentive to, the "time out" procedure and the detail of what was recorded on the consent form. The MPT rejected this submission. It considered that the balance of the evidence "plainly demonstrates" that the consent form was altered later. It considered that there were "numerous possibilities" for explaining the failure of the surgical team to notice the discrepancy, including that the Appellant had not been present at the "time out" procedure, or that if he was present that he was not paying sufficient attention to the content of the consent form.

*Misconduct*

22. The MPT heard expert evidence from Mr Reynard (a consultant urological surgeon, instructed on behalf of the Appellant) and Mr Prendergast (a consultant gynaecologist, instructed by the Respondent). They both considered that the Appellant should have reviewed Patient A's consent form and medical notes so as to ensure that informed consent had been properly obtained. The MPT accepted that evidence and considered, in any event, that it is "self-evident" that a surgeon performing this procedure should "at the very least" ensure that the consent form corresponds to the medical notes.

23. The MPT accepted that there had been systemic failures which had contributed to the outcome, but considered that these did not absolve the Appellant of responsibility. It found that his conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to serious misconduct. In particular, it found the following allegations proved:

    (1) The Appellant failed to review the consent form and medical notes so as to ensure that informed consent had been properly obtained;

    (2) The Appellant failed to (a) conduct a face-to-face meeting with Patient A, (b) review Patient A's medical records, (c) confirm Patient A's medical history, (d) review and confirm the contents of Patient A's consent form, (e) confirm that the decisions arrived at by Patient A still applied;

    (3) The Appellant performed a vaginectomy which Patient A (a) did not want, and (b) had not consented to;

    (4) The Appellant performed the vaginectomy despite (a) entries in Patient A's records stating that he did not want the vaginectomy, and (b) there being no properly completed form recording Patient A's consent to the vaginectomy.

*Impairment*

24. It was submitted on behalf of the Appellant that he "had been as much a victim of a flawed system as Patient A." He had now changed his practice: now, he personally ensures that his patients consent to the operations he performs. Accordingly, so it was said, this isolated failing had been fully remedied such that there was no ongoing impairment of his fitness to practise.

25. The MPT accepted that the Appellant's misconduct was "remediable", that it had been "remedied to an extent" and that the risk of repetition was low. However, it considered that he had shown limited insight and had not taken full responsibility for his error, and that he had appeared to be unwilling and/or unable to recognise his personal fault. It pointed out that during the initial investigation the Appellant had appeared to dismiss the possibility that a mistake may have occurred, even though it was clear (from Patient A's medical notes and what Patient A said in his complaint) that Patient A had not wanted a vaginectomy. Once the discrepancy in the consent forms came to light, the Appellant continued to maintain that Patient A had given his consent. Again, he did not appear to recognise the contrary possibility. The MPT considered that the Appellant's misconduct was too serious, and the consequences too grave, to conclude that the Appellant's fitness to practise was not impaired.

*Sanction*

26. It was submitted on behalf of the Appellant that he did not present a risk to public safety and that suspension would be disproportionate and contrary to the public interest, having regard to the public interest in the Appellant (who was one of only two surgeons who undertook this combination of procedures) being available to a vulnerable cohort of patients who make life changing decisions. The MPT considered that it would be wholly inappropriate to take no action and that would not uphold the over-arching objective of protecting the public. It did not consider that the imposition of conditions on the Appellant's registration would adequately protect public confidence or uphold proper standards of conduct. It considered that suspension for 5 months was the appropriate and proportionate sanction, and that no lesser sanction would adequately promote and maintain public confidence or maintain proper professional standards.

## Legal framework

27. There is no dispute between the parties as to the applicable framework or the principles that emerge from the authorities. In the light of the helpful and constructive approach taken by both Mr Forde QC for the Appellant, and Ms Hearnden for the Respondent, it is only necessary to provide a brief summary.

28. The framework is set out in the Medical Act 1983, the General Medical Council (Fitness to Practise) Rules Order of Council 2004, and non-statutory "Sanctions Guidance" published by the Respondent.

29. The over-arching objective of the Respondent in the exercise of its functions is the protection of the public – s1(1A) Medical Act 1983. The pursuit of that objective involves (amongst other matters) the maintenance and promotion of public confidence in the medical profession and proper professional standards and conduct by members of that profession – s1(1B).

30. It was for the MPT to determine the facts, make findings on the allegations of misconduct that were advanced, and then to determine whether the Appellant's fitness to practise was impaired by reason of misconduct, and then to determine what, if any, sanction should be imposed.

31. Misconduct includes a serious failure to meet the necessary standards of medical practice, such as culpable carelessness in the provision of treatment – *Roylance v General Medical Council (No 2)* [2000] 1 AC 311 *per* Lord Clyde at 331B-G (and see, for the interplay between the concepts of negligence, misconduct and deficient professional performance, *R (Calhaem) v General Medical Council* [2007] EWHC 2606 (Admin) *per* Jackson J at [39] and *Preiss v General Dental Council* [2001] UKPC 36 [2001] 1 WLR 1926 *per* Lord Cooke at [28]).

32. Where a doctor has fully addressed concerns about their knowledge, skills, conduct or behaviour ("remediation") then it is unlikely that their fitness to practise will be impaired – see paragraph 31 of the Sanctions Guidance. Paragraphs 32 -33 add:

> "32. However, there are some cases where a doctor's failings are irremediable. This is because they are so serious or persistent that, despite steps subsequently taken, action is needed to

> maintain public confidence. This might include where a doctor knew, or ought to have known, they were casing harm to patients and should have taken steps earlier to prevent this.
>
> 33. In such serious cases, the tribunal must fully and clearly explain:
>
> a. the extent to which the issues can be remediated
>
> b. the steps the doctor has taken
>
> c. how the seriousness of the findings – including the doctor's failure to take steps earlier – justifies the tribunal taking action, notwithstanding the steps subsequently taken."

33. Where a tribunal finds a doctor's fitness to practise is impaired it can take no action, or accept undertakings, or impose conditions on the doctor's registration, or suspend registration for up to 12 months, or erase the doctor's name from the register. It should start by considering the least restrictive option and then work upwards to the most appropriate and proportionate sanction – see paragraphs 66 and 67 of the Sanctions Guidance.

34. Paragraph 92-93 of the Sanctions Guidance states:

> "92. Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).
>
> 93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions..."

35. The Appellant has a right of appeal to the High Court against the decision of the MPT that he should be suspended – s40(1)(a) Medical Act 1983. An appeal is by way of re-hearing – CPR PD52D paragraph 19. An appeal will be allowed where the decision of the MPT was wrong – CPR 52.21(3)(a). In assessing whether the MPT's decision is wrong it is necessary to allow for the advantages enjoyed by the MPT, having regard to its specialist expertise, and the fact that it heard and saw the witnesses – see *Yassin v General Medical Council* [2015] EWHC 2955 (Admin) *per* Cranston J at [32], *Dutta v General Medical Council* [2020] EWHC 1974 (Admin) *per* Warby J at [21].

## The appeal

36. It is convenient to approach the grounds of appeal (as Ms Hearnden did) by reference to the structure of the MPT's determinations, and in particular (1) the MPT's findings of fact (paragraphs 16 - 21 above), (2) the finding of misconduct (paragraphs 22 - 23 above), (3) the finding of impairment (paragraphs 24 - 25 above), and (4) the sanction of a (non-immediate) suspension of 5 months (paragraph 26 above). In adopting that approach, I nonetheless recognise that the Appellant has not categorised the grounds in quite that way, and that some of the grounds straddle more than one of these headings (in particular, there is overlap between his criticisms of the MPT's findings of misconduct and impairment).

*Factual findings: grounds 1-3*

37. The central challenge is to the MPT's finding that the consent form was altered after the time out procedure. This is put in various ways. Ground 1 contends the MPT was wrong to consider it possible that the Appellant had not been present at the time out procedure, that it should not have speculated as to the different possibilities, and that it should not have found that the consent form was altered after the time out procedure. Ground 2 contends that there was no evidence on which the panel could have safely concluded that the consent form was not altered prior to the time out procedure. Ground 3 contends that the MPT's finding was illogical, irrational and not supported by the evidence.

38. Mr Forde QC argues that the MPT should have found that Dr Capece altered the consent form before the time out procedure, and that the word "vaginectomy" was therefore read out from the consent form during the "time out" part of the checklist. On the evidence, it would have been noticed by the team if the consent form did not include reference to a vaginectomy: there were a number of clinicians present and it would only have taken one of them to spot the discrepancy. The fact that an amendment was made to make it clear that the hysterectomy was to be carried out by laparoscope shows that the clinicians were focussed and paying close attention to the content of the form. He argues that the MPT should not have speculated as to possible reasons why the discrepancy might not have been noticed, and that it was not open to the MPT to find that it was possible that the Appellant had not been present at the sign in procedure.

39. Discussion: There is now no challenge to the MPT's rejection of the evidence given by the Appellant and Dr Capece that Dr Capece had, on the morning of 29 October 2016, consented Patient A for a vaginectomy. The MPT gave clear and cogent reasons for that conclusion which were predominantly (but not exclusively) based on the fact that Patient A would not have given such consent. Having rejected Dr Capece's account, it did not have any direct factual evidence as to the circumstances in which the amendment was made. It was clear that it was not written before the "sign in" procedure, again because this would have resulted in objection from Patient A. There would have been no reason for Dr Capece to make the amendment in the limited window between "sign in" and "time out". He knew that he did not have Patient A's consent. There would have been no motive or other rational reason, in advance of the surgery, for an amendment to be made to the consent form which Dr Capece would have known to be untrue. As the MPT found, "it was improbable that Dr Capece would encourage the surgical team to perform a procedure which he had no reason to believe Patient A wanted." This reasoning is convincing. It does, however, leave open the

question as to whether the discrepancy (ie the absence of vaginectomy from the consent form) could really have been missed at the "time out" procedure. In the absence of clear and reliable positive evidence on that issue, the MPT was entitled to consider the logical possibilities: if, on the evidence, it was not possible for the discrepancy to have been missed then that in itself would show that the amendment had been made before the commencement of the surgery.

40. More than one witness suggested that the discrepancy would have been noticed. However, on analysis of the evidence of each individual clinician (see paragraph 17 above) it is clear that, with the exception of the Appellant and Mr Capece, each individual witness readily accepted that they may well not have noted the absence of the word "vaginectomy". So far as the Appellant and Mr Capece are concerned, the MPT was entitled to find, for the reasons it gave, that their evidence was not reliable. No doubt, if the Appellant had been present and fully focussed on what was being said, he would have noted the discrepancy. He was well aware that a metoidioplasty did not necessarily include a vaginectomy. He was also well aware that consent for the former was not sufficient consent for the latter. The MPT was, however, entitled to conclude that it had not been demonstrated on the evidence that the Appellant was present and playing close attention. It was, on the evidence, a possibility that he had not been present, or that he had been present but paying insufficiently close attention. Mr Rich had given evidence that he would have ensured that the Appellant was present, and Ms Kokka said that the "whole team" would have been present, but that evidence of their respective expectations falls short of infallible definitive testimony that he was in fact present throughout the process. The MPT was entitled to note the logical possibility that, for whatever reason, the Appellant had not been present (and there was positive evidence that he did, at one point, leave for a period of time to attend to other duties, albeit his case was that this was after the "time out" checklist had been completed). The MPT was likewise entitled to note the contrary possibility – that he had been present but had not noticed that the consent form did not include reference to a vaginectomy. The Appellant was, on his account, fully expecting to perform a vaginectomy. That was what the theatre list recorded. In the vast majority of cases a vaginectomy is performed at the same time as the second stage of a metoidioplasty. The reliability of the Appellant's evidence and attention to detail had already been impugned (because of the rejection of his account that he had asked for a "double check"). Mr Reynard's evidence was that his experience of the "time out" procedure is that the group "not infrequently are on auto-pilot and as such do not fully concentrate on the process." Of course, this reflects Mr Reynard's general experience rather than the approach that the Appellant, in particular, takes, but it does demonstrate that not every surgeon invariably pays meticulous attention to every detail of the "time out" process. On the totality of the evidence, it was entirely open to the MPT to countenance the possibility that the Appellant had not paid sufficient attention to notice the omission.

41. For these reasons I dismiss the first three grounds of appeal. The MPT was not wrong to find that the amendment was made after the "time out" procedure.

*Misconduct: grounds 4, 7 and 8*

42. The Appellant correctly points out that the MPT accepted that the Appellant believed that Patient A had consented to a vaginectomy. That belief was based, in part, on a combination of communication failings and systemic failings. In those circumstances the Appellant contends it was irrational to find serious misconduct based on a single

failure involving one patient (ground 4), that the MPT erred in finding that the Appellant was not entitled to rely on the systemic failings so as to absolve him to a greater extent from his own deficiencies (ground 7), and that it erred in making a finding of serious misconduct when this was "mere negligence at worst" (ground 8). Mr Forde QC argues that the MPT "reneged" from its findings that there had been systemic failings and that the Appellant had held an honest belief in Patient A's consent.

43. Discussion: There had certainly been significant failings for which the Appellant was not responsible. These included the compilation of the booking form and the theatre list, both of which wrongly referred to a vaginectomy, and neither of which were the responsibility of the Appellant. The MPT rightly recognised these as significant errors. Mr Forde QC is also right to observe that the WHO checklist could be designed in a different way so as more clearly to rule out the possibility for errors in the consenting process.

44. These grounds of appeal do not, however, fully accommodate and engage with the MPT's factual findings. The Appellant's erroneous belief in Patient A's consent was not wholly due to the booking form or the theatre list. It was also due to the fact that he did not see Patient A before the surgery, did not read Patient A's notes with sufficient care, and did not adequately check that Patient A had consented to a vaginectomy. The characterisation of this as a "single failure" risks understatement. In any event, there is no rule of law that a single failing in respect of a single patient cannot amount to serious misconduct. A single failure may be less likely to meet the threshold of seriousness and culpability than multiple failings, but whether or not it does so is an assessment to be made on the evidence of a particular case.

45. The MPT heard evidence from two expert witnesses who were both (in the event that, as the MPT found, the amendment to the consent form was made after "time out") highly critical of the Appellant's conduct. Mr Prendergast said:

> "Since Dr Garaffa did not meet personally with Patient A at any time prior to undertaking major surgery, and since the circumstances did not justify the delegation of the obtaining of written consent to a colleague, in my opinion he performed a vaginectomy without Patient A's consent. In my opinion to operate upon Patient A without consent falls seriously below the standard expected of a reasonably competent consultant performing vaginectomy surgery.
>
> I have concluded that this falls seriously below the standard expected since to treat the patient without consent is in breach of paragraph 17 of Good Medical Practice and could reasonably be characterised as an assault. The consequences to Patient A of undergoing a vaginectomy without consent are permanent and life-changing in that he has been deprived of any possibility of vaginal function.
>
> …
>
> In my opinion, the failure of Dr Garaffa to personally assess Patient A, the failure to adequately review the medical records, as well as the inappropriate delegation of [Dr Capece] to seek written consent, led directly to the destruction of Patient A's

> vagina without consent. Although there is no reason to doubt that the surgical procedure was performed competently, the cumulative effect of the omissions listed above lead me to conclude that the overall standard of care fell seriously below the standard expected of a reasonably competent consultant performing vaginectomy surgery."

46. Dr Raynard took a slightly different view in respect of the permissibility of delegating the consent procedure to Dr Capece, and suggested that there are many occasions when such delegation does take place. Nevertheless, he agreed with Mr Prendergast that it was a serious failure to perform a vaginectomy where there was no written consent:

> "If the consent form that was read out at the WHO surgical time-out did not contain the word vaginectomy, then it was not reasonable for Mr Garaffa to conclude that a vaginectomy was to be performed and to have carried out a vaginectomy was a serious failure."

47. Dr Raynard did not consider that the systemic failings absolved the Appellant from responsibility:

> "In my opinion he did bear responsibility to check that things done in his name, as the consultant surgeon (as a surgical team leader) responsible for the safe running of his operating list, were done.
> …
> The final link in the chain was the failure, on the day, for Mr Garaffa to personally check that the correct procedure was undertaken and the checking behaviour failures of the surgical team on the day. As the consultant in charge for the urological aspects of the operating list, in my opinion Mr Garaffa must take responsibility for his failure to check what was done and what was not done on his Operating list."

48. This evidence is consistent with the Respondent's published guidance "Consent: patients and doctors making decisions together" which (in the version that was current at the relevant time) stated at paragraphs 26-27:

> "**Responsibility for seeking a patient's consent**
>
> 26 If you are the doctor undertaking an investigation or providing treatment, it is your responsibility to discuss it with the patient. If this is not practical, you can delegate the responsibility to someone else, provided you make sure that the person you delegate to:
>
> a is suitably trained and qualified
>
> b has sufficient knowledge of the proposed investigation or treatment, and understands the risks involved

> c understands, and agrees to act in accordance with, the guidance in this booklet.
>
> 27 If you delegate, you are still responsible for making sure that the patient has been given enough time and information to make an informed decision, and has given their consent, before you start any investigation or treatment."

49. Although the MPT correctly found that there were systemic failings that contributed to the outcome, it was also right, on the evidence, to find that this did not absolve the Appellant of responsibility. It was right to reject the suggestion that he was just as much a victim of systems failures as Patient A. On the evidence, the Appellant had every opportunity to avoid the outcome that materialised, by doing that which he should have done. He therefore bore a significant degree of responsibility for the outcome. The expert evidence, the published guidance, and the MPT's own sense, as an expert tribunal, of the standards of professional conduct that are to be expected, all pointed to a finding of misconduct. I do not consider that the MPT's finding of misconduct can be faulted in any way.

*Impairment: grounds 5-6 and 9-10*

50. The Appellant contends that the MPT was wrong to find an impairment of the Appellant's fitness to practise given that the Appellant had changed his approach to ensuring consent and there was no evidence of repetition of the conduct (ground 5), that the MPT was wrong to find that he had only shown limited insight and had not taken full responsibility (ground 6), that the finding of a lack of insight went against the weight of the evidence and testimonials (ground 9), and that the MPT was wrong to find that the need to uphold, promote and maintain public confidence mandated a finding of impairment (ground 10).

51. Mr Forde QC submitted that it should be rare for a single failure involving a single patient to amount to either serious misconduct or impairment of fitness to practise, that this was a single incident in a distinguished career, that there were numerous, extensive and impressive testimonials (see paragraph 15 above), and that the Appellant had provided detailed evidence about his changes in procedure. He was strongly critical of the MPT's finding that the Appellant had (only) remediated his conduct "to an extent" and its failure (as he suggested) to spell out what more the Appellant could or should have done. He contended that the Appellant was "entitled to assume" that Patient A had been appropriately and fully consented.

52. Discussion: I accept the submission as to the Appellant's career and testimonials, that the misconduct concerned a single patient and that the Appellant had changed his approach.

53. However, in approaching the question of impairment, the MPT was required to have regard to the over-arching objective of protecting the public, which includes the objective of maintaining public confidence and proper professional standards (s35E(6) of the 1983 Act). An anaesthetised patient is in a paradigm position of vulnerability. The imperative for public confidence in the consent process that is carried out before an anaesthetic is administered is self-evident. For that reason, it is imperative that the

medical profession ensures rigorous compliance with the consent requirements, as the expert witnesses both recognised, and as is made clear in published guidance. There was therefore no error in the MPT's attention to the seriousness and consequences of the Appellant's conduct when assessing if his fitness to practise was impaired. That is so irrespective of the question of remediation, insight and risk of repetition: the Respondent's guidance makes it clear that an impairment can be found even where there is no risk of repetition (see paragraph 32 above).

54. In any event, the MPT was entitled to conclude that the Appellant had not fully remediated his conduct and that he had shown some, but not full, insight into the responsibility he bore for the outcome. The MPT recognised that he had changed his approach to consent and that he now conducted the consent process personally. However, the Appellant's failings did not start and stop with the failure personally to see the Appellant. There was a broader attitude (albeit the MPT did not use that word) which underlay the failure to ensure Patient A's consent. So far as consent is concerned, that attitude manifested itself in the Appellant's willingness to commence a major elective and irreversible surgical procedure on a patient who he had not seen, whose notes he had not read with any care, and whose consent form he had not read or listened to with sufficient care. The MPT identified other manifestations of the same attitude. Thus, when Patient A made a complaint, the Appellant did not appear willing to conceive of the possibility that an error of some sort may have occurred – he was adamant that Patient A had consented to the procedure and was therefore dismissive of the complaint. Even when the discrepancy between the consent forms emerged, he was not apparently willing to accept, as a possibility, that Patient A had not consented. Of course, he was seriously let down by the dishonesty of his assistant, Dr Capece. It is perhaps not surprising that he was more inclined to believe Dr Capece over Patient A. However, the MPT were entitled to consider that the refusal even to acknowledge the possibility of error in circumstances where Patient A's medical notes, Patient A's complaint, and the fact of the discrepancy pointed in that direction, betrayed limited insight and was something that had not fully been remediated. The MPT saw, heard and observed the Appellant over an extended period of time. It had a wealth of material before it. It was in the best position, and in a far better position than an appellate court, to make this type of factual assessment.

55. The MPT did make brief reference in its factual determination to the testimonial letters in support of the Appellant. Mr Forde QC fairly and accurately points out that it did not address them in any detail, and it did not separately explicitly reference them in the context of its determination as to impairment. Nevertheless, it clearly had them in mind. They portray a different picture (see paragraph 15 above) from the impression that might be gained from the facts of this single case viewed in isolation. However, the MPT took a holistic and balanced view of the case. I am satisfied that although it did not reference the detail of the testimonials, it fully took them into account (see, further, ground 12 below), as well as the submissions that were advanced by reference to them on the Appellant's behalf. There is nothing in its reasoning or conclusion that can be said to be wrong.

*Sanction: grounds 11-15*

56. The Appellant contends that the MPT failed to give sufficient weight to the finding that the Appellant had made an "honest mistake" (ground 11), failed to attach sufficient weight to the testimonial evidence (ground 12), failed to give sufficient weight to the

impact of the Appellant's suspension on patients that required his services (ground 13), imposed a sanction that was purely punitive and was reliant on the outcome for Patient A rather than the Appellant's culpability (ground 14), and wrongly rejected a submission that the finding of impairment was in itself sufficient sanction without giving reasons beyond invocation of the over-arching objective, which was "a device to circumvent" the Appellant's insight, remorse and contrition (ground 15).

57. Mr Forde QC is critical of a submission that was advanced by the Respondent before the MPT (not by Ms Hearnden) to the effect that the Appellant had been dishonest in his evidence to the MPT. He argues that "at worst" the Appellant's evidence comprised an honest but mistaken recollection of events. Moreover, there could be no suggestion that the Appellant was complicit in, or responsible for, Dr Capece's dishonest amendment of the consent form.

58. Discussion: The MPT explicitly had regard to the Respondent's published guidance on indicative sanctions. It took account of the aggravating and mitigating features. As to the former, it identified the serious and avoidable nature of the incident which itself involved numerous failings amounting to a relinquishment of the Appellant's responsibility to ensure that consent had been obtained, the serious and irreversible consequences for Patient A, and the Appellant's limited insight. The MPT was entitled to regard each of these as aggravating features. In mitigation it took into account that only one patient was involved (and "to this extent" it was a single / isolated incident), that it was a genuine mistake, that there was a degree of remediation in that the Appellant had changed his practice so that he now consented his patients himself, that he had accepted personal responsibility, was remorseful and genuinely regretted the incident, that there had been a lapse of time since the incident with no repetition, and that the risk of repetition was low.

59. Insofar as the MPT took a different view of remediation and insight from that which has been advanced by Mr Forde QC it was entitled to do so for the reasons given above (see paragraph 54). Aside from the question of testimonials, it has not been suggested that there is any other factor that the MPT did not take into account in mitigation. As to testimonials, it is right that their content is not explicitly mentioned as a mitigating factor. However, the MPT recorded that it took into account "the documentary evidence adduced" (which included the testimonials) and its recognition that this was an "isolated incident" (in the sense it described), and its later reference to an "otherwise unblemished career" is entirely consistent with the glowing content of the testimonials. It took into account the fact that the Appellant worked "in a very specialised field" and that there was "a public interest in his returning to safe practice."

60. To the extent that the GMC had submitted that the Appellant had given dishonest evidence, it is clear that the MPT did not accept that submission. It did not make any finding of dishonesty against the Appellant, and its findings on sanction were entirely consistent with its finding that this had been an "honest mistake." The MPT adopted the approach that is prescribed by the Respondent's published guidance on the imposition of sanctions. It considered the lowest possible sanction first, only moving up the sanctions ladder once that was rejected. The sanction imposed, 5 months suspension, fell short of the ultimate sanction that could have been imposed (erasure from the register). It also fell short of the maximum period of suspension that could have been ordered, which was 12 months. It was also not imposed with immediate effect.

61. The MPT was not just entitled, but required, to have regard to patient safety and patient confidence. By doing so it was not adopting a "device" to circumvent such insight and remediation as had been demonstrated. Rather, it considered the evidence of insight and remediation in the context of its statutory obligation to assess the appropriate sanction with regard to the objectives of protecting the public, including promoting and maintaining public confidence, and proper professional standards. That was the correct approach.

62. It was faintly suggested that the Appellant's sanction did not bear comparison with the sanction imposed on Dr Capece (a 12 month suspension) given that the latter had acted dishonestly. However, the latter sanction was significantly more stringent – the length of suspension being 140% greater than that imposed on the Appellant, the Appellant was the more senior doctor, and it was the Appellant who bore ultimate responsibility for ensuring that Patient A had consented. Whether or not Dr Capece was fortunate not to face a sanction of erasure from the register, the decision in Dr Capece's case does not indicate that the decision in the Appellant's case was wrong.

63. I am therefore satisfied that there was no error in the MPT's finding on sanction.

## Outcome

64. There is no error in the MPT's conclusions that:

(1) Patient A did not consent to the vaginectomy,

(2) the amendment to the consent form to include "vaginectomy" was made after surgery commenced,

(3) the Appellant's failure to ensure he had Patient A's consent for the surgery amounted to misconduct,

(4) the Appellant's fitness to practise was impaired by reason of that misconduct,

(5) the Appellant should be suspended for a period of 5 months.

65. The appeal is therefore dismissed.