PUBLIC RECORD

Dates: 07/08/2023 - 23/08/2023

Medical Practitioner's name:	Dr Carlos Gomes De Sanches Damas
GMC reference number:	7243661
Primary medical qualification:	Lic Med 2002 Universidade Nova de Lisboa

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

Summary of outcome

Suspension, 12 months.
Review hearing directed
Immediate order imposed

Tribunal:

Legally Qualified Chair	Ms Alice Moller
Lay Tribunal Member:	Mr John Ennis
Medical Tribunal Member:	Dr Nagarajah Theva

Tribunal Clerk:	Ms Ciara Fogarty

Attendance and Representation:

Medical Practitioner:	**Not present and not represented**
GMC Representative:	Ms Ceri Widdett, Counsel

Attendance of Press / Public

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

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 - 16/08/2023

1. This determination will be handed down in private. However, as this case concerns Dr Gomes de Sanches Damas' conduct, a redacted version will be published at the close of the hearing.

Background

2. Dr Gomes de Sanches Damas (Dr Damas) qualified in 2002 from Universidade Nova de Lisboa. Until the events which are the subject of this hearing, Dr Damas was working as a consultant general surgeon at Frimley Park Hospital.

3. It is alleged by the GMC that, on 25 September 2018, Dr Damas obtained a signed consent form from Patient A to undergo a procedure by the 'open' approach (only) but that Dr Damas commenced the procedure by laparoscopic approach that same day, without obtaining further consent from his patient for 'keyhole' surgery.

4. It is also alleged that Dr Damas amended the master copy of this consent form after the original version had been signed by Patient A. The GMC further allege that Dr Damas knew that the scope of Patient A's consent was limited to an 'open' approach and that Dr Damas' amendment of the consent form was dishonest, as Dr Damas knew Patient A had not consented to a laparoscopic 'keyhole' approach.

The Outcome of Applications Made during the Facts Stage

5. The Tribunal granted the GMC's application under Rules 20, 31, 40 of the General Medical Council (Fitness to Practise Rules) 2004 as amended (the Rules) to proceed in the absence of Dr Damas, reasonable efforts having been made to serve Dr Damas with relevant

documents at the most recent address provided to the GMC. The Tribunal's full decision on this application is at Annex A.

The Allegation and the Doctor's Response

6. The Allegation made against Dr Damas is as follows:

1. On 25 September 2018 you obtained Patient A's signed consent to undergo a cholecystectomy ('the Procedure') by the open approach. To be determined

2. On 25 September 2018 without obtaining further prior consent from Patient A, you commenced the Procedure by laparoscopic approach. To be determined

3. On a date and at a time unknown but after the consent form for the Procedure was presented to and signed by Patient A, you amended the master copy of the consent form in that you:

    a. added the word 'laparoscopy' in the 'Name of proposed procedure or course' section; To be determined

    b. added the word 'laparotomy' in the 'other procedure (please specify)' section; To be determined

4. When you acted in the manner described at paragraph 3, you knew that:

    a. Patient A had consented to the Procedure being carried out by the open approach; To be determined

    b. Patient A had not consented to the Procedure being carried out by the laparoscopic approach; To be determined

5. Your conduct at paragraph 3 was dishonest by reason of paragraph 4.

    To be determined.

Witness Evidence

7. The GMC presented evidence to the Tribunal from the following witnesses:

- Patient A, by video link;
- Dr B, Senior House Officer, by video link.

8. The GMC also provided the Tribunal with a witness statement from the wife of Patient A, who was not called to give oral evidence.

9. Dr Damas did not provide a witness statement or give oral evidence.

Expert Witness Evidence

10. The Tribunal heard evidence by video link from Mr C, Consultant General Surgeon, an expert witness called by the GMC. He had provided two expert reports, first dated 6 June 2022 and a supplemental report dated 26 April 2023. Mr C gave evidence about gallstone disease, laparoscopic 'keyhole' surgery, 'open' approach to a cholecystectomy, risks and benefits of surgical options, as well as the process of obtaining informed consent from a patient.

Documentary Evidence

11. The Tribunal was provided with bundles of documents, including the following:

- Letter from Dr Damas to Dr D, GP, dated 26 June 2018
- Consent forms (part/full) signed by Patient A dated 25 September 2018
- Consent form (full) provided by the Frimley Health NHS Foundation Trust (the Trust) to Patient A provided on 19 September 2019
- Operating Theatre Note dated 25 September 2018
- Letter from Mr E, Director of Nursing and Quality at the Trust to Patient A dated 14 February 2019
- Letter from Ms F, Complaint Co-ordinator at the Trust to Patient A dated 26 April 2019
- Referral to the GMC by Patient A dated 29 March 2021
- Consent form completed by Dr B and another dated 25 September 2018
- GP records (various dates) for Patient A
- Hospital records (various dates) for Patient A.

Advice from legally qualified chair (LQC)

12. The LQC advised the Tribunal that the burden of proving disputed facts is on the GMC. Dr Damas does not need to disprove anything in the Allegation. Dr Damas is only obliged to answer specific allegations against him and no others: *Roomi v GMC* [2009] EWHC

2188.

13. The LQC reminded the Tribunal that the standard of proof required is the civil standard, the balance of probabilities. *Re B children* [2008] UKHL 35 confirmed that, while the seriousness of an allegation, or its consequences, may necessitate more careful consideration of the evidence, this does not affect the test to be applied.

14. The more improbable it is that Dr Damas would have behaved as alleged, the more cogent or credible the evidence may need to be to prove on the balance of probabilities that he did as alleged: *Virdee v GPhC* 2015 EWHC 169. Where an event is inherently improbable, it may take better evidence to prove it; this goes to the quality of evidence: *Byrne v GMC* [2021] EWHC 2237.

15. The LQC reminded the Tribunal that counsel's submissions are not evidence, and the Tribunal should draw its own conclusions from what it has seen and heard.

16. The Tribunal was advised that it may accept unsupported evidence from any witness, but an account of events should be given more weight if it has been tested in cross-examination.

17. The Tribunal should analyse the evidence fairly and impartially, taking account of any gaps or inconsistencies, as well as any apparent contradictions. Corroboration may be considered to increase the likelihood of a particular assertion being accurate.

18. The Tribunal should consider all the evidence before drawing conclusions about the credibility of any account of events. The Tribunal may take account of conflicts in evidence as well as denials: *Khan v GMC* [2021] EWHC 374.

19. The Tribunal is entitled to draw inferences, reach common sense conclusions based on reliable evidence that the Tribunal accepts. However the Tribunal should avoid any speculation on matters about which there is no, or insufficient, evidence.

20. The LQC advised that a Tribunal may draw such inferences as it considers appropriate from primary facts. Ms Widdett, on behalf of the GMC, invited the Tribunal to draw an adverse inference from Dr Damas' absence at this hearing, such as his lack of an innocent explanation.

21. In *Radeke v General Dental Council* [2015] EWHC 778 the court said that It could envisage circumstances in which a practitioner unfit to attend a hearing would nevertheless be capable of providing a witness statement.

'Where such a practitioner fails to produce such a statement, circumstances may arise in which an adverse inference could be drawn in accordance with the approach of the Court of Appeal in **Wiszniewski** *v Central Manchester HA [1998] EWCA 596.'*

22. The LQC said that any such adverse inference could be only one part of the totality of the evidence; an adverse inference alone cannot amount to determinative proof. The Tribunal must provide clear reasons for any conclusions that it draws, but it is not obliged to draw an adverse inference from Dr Damas' absence.

23. The test for dishonesty is set out in *Ivey v Genting Casinos 2017 UKSC 67*. The Tribunal must first ascertain (subjectively) the state of Dr Damas' knowledge or belief as to the facts. The reasonableness of the belief is a matter of evidence going to whether he genuinely held the belief, but it is not a requirement that the belief must be reasonable. Then the Tribunal must consider whether that conduct was dishonest by the (objective) standards of ordinary decent people.

24. Although an assessment of credibility is not required in every situation, Tribunal should provide an adequate explanation if it concludes that what was inherently improbable has been established: *McLennan v GMC [2020] CSIH 12.*

25. The Tribunal was reminded that although it does not provide a defence, good character is an important factor capable of assisting Dr Damas in two ways: in relation to credibility as well as propensity. Although he has not given evidence, he has explained some of his actions in discussion with the Trust and correspondence. Good character must be considered when assessing whether Dr Damas' explanations are likely to be true. Second, the fact that Dr Damas has no cautions, convictions or regulatory history goes to the likelihood of him acting as alleged by GMC.

26. *Wisson v HPC [2013] EWHC 1036* confirmed that good character is clearly relevant when the credibility of a doctor is an issue. Judging the weight to be given to good character and its relevance at the Facts stage is a matter for the Tribunal.

27. Finally, the LQC advised the Tribunal that it must consider, separately, the evidence in relation to each allegation. If it finds one allegation proved, or not proved, it does not follow that the Tribunal will reach the same conclusion in relation to other allegations. The Tribunal must be satisfied that each element of an allegation has been made out before finding a specific allegation proved.

The Tribunal's Analysis of the Evidence and Findings

28. In reaching its decision on facts, the Tribunal took account of all evidence provided, including Dr Damas' account of events in his response to Patient A's complaint, provided by the Hospital. Dr Damas is not obliged to give evidence to the Tribunal or to provide a witness statement. He is entitled to put the GMC 'to proof' so the Tribunal need not draw an adverse inference from his absence, or lack of formal evidence; Dr Damas has sought to explain his actions, including in correspondence.

29. The Tribunal has considered each paragraph of the Allegation separately and has evaluated all evidence to make its findings on the facts. Dr Damas was not obliged to give evidence to this hearing or to provide a witness statement. The Tribunal did not draw any inference from his absence or lack of statement.

Paragraph 1

30. The Tribunal took account of written evidence from Patient A. His witness statement provided a detailed account of events. Patient A said he first saw Mr Damas on 30 April 2018 with his wife:

> *'I do not remember specifically what Mr Damas said, but I know that he told me my gallbladder needed to come out. He told me about the normal procedure for this surgery and that it would usually be keyhole surgery. He used the term keyhole rather than laparoscopic, which is the technical term for it… Mr Damas stated that there was a need to do my operation open rather than through keyhole surgery. He did not elaborate much more on this, but just said it was due to previous operations'.*

31. His wife confirms this in her witness statement:

> *'At this appointment, I recall that Dr Damas examined Patient A and explained that based on the results he had, Patient A needed to have his gall bladder removed. I remember Dr Damas explained that normally this would be done by a keyhole procedure, but because Patient A had had previous procedures to remove bowel cancer when he was about 45 years old, there was ''a need to perform open surgery'' because he would have scar tissue from previous surgery. From memory, these were Dr Damas' exact words. Patient A was happy for the procedure to go ahead as an open procedure. At no point was it ever suggested that Patient A's gall bladder would be removed by anything but an open procedure.'*

32. On 11 September 2018 Patient A had a further appointment with Mr Damas after his pre-operative assessment. Patient A says in his witness statement:

> *'I went to this meeting with Mr Damas on my own and very little was discussed at this appointment. There were no discussions about whether the surgery would be open or keyhole. It had already been decided that it would be done via open surgery, so I presumed this was how it would be done.'*

33. As to 25 September 2018, the day of surgery, Patient A's witness statement says:

> *'Mr Damas did not come to see me before the surgery. I definitely did not have any discussions with him about whether the surgery would be done via open or keyhole surgery. No one else came to speak to me about the procedure. I was not told that the procedure would be started laparoscopically but there was a high chance it would need to be converted to open. You cannot have a conversation with someone that you have not met before the surgery…*
>
> *…I arrived at the Hospital with my wife and we sat in the waiting room together until I was called to go into the side room to be undressed to get ready for the operation. From memory I walked with a nurse to the operating theatre. My wife was told that there was no point in her waiting. I walked into the operating theatre and I was in the outer room where you get prepared. I recall that there was a nurse either side of me and I was getting needles put in me. I believe it was at this time that I was given the consent form to sign… I do not believe that I had any prior discussions to this about consent and I did not sign any consent forms at my first two appointments with Mr Damas.*
>
> *No one spoke to me about what the consent forms said. At the time I was having needles put [in] me, so I do not think I read the consent form, I just signed it. I was getting ready for the operation and I had already been told what I was going to have done. The consent form was put on my lap and I just signed it. I was getting put to sleep at this time, but I think I saw the consent form around 10 or 15 minutes before going into theatre. There was a lot going on. I did not see Mr Damas alter the consent form in front of me at any point. I did not see Mr Damas before the surgery and I did not have any discussions with him about the consent form.'*

Patient A said he did not see Mr Damas again until he came around after surgery.

34. Mr C, expert witness for the GMC, gave evidence in relation to consent, that he was '*absolutely certain'* that Patient A consented to the open procedure, not keyhole. Patient A's admission documents record that he had been admitted for an '*open lap chole*' [laparotomy cholecystectomy]. Mr C's view was based on his review of clinical records, including letters, in the context of his expert knowledge.

35. The Tribunal took account of the consent form referring to 'cholecystectomy' signed by Patient A on 25 September 2018. Patient A gave a consistent and plausible account to the Tribunal that Dr Damas discussed surgery and strongly recommended a cholecystectomy by open approach, as opposed to 'keyhole' or laparoscopic.

36. The Tribunal considered the letter from Dr Damas to Dr D at Heath Hill Surgery dated 26 June 2018. This sets out Dr Damas' advice and intended approach. The letter supports Patient A's evidence. Dr Damas wrote to the GP:

> *'I reviewed this gentleman in our clinic. [Patient A] has been experiencing ongoing pain in his right upper quadrant related to gallstones. We have performed an MRCP that revealed low evidence of stones in the common bile duct, however reveals four small potentially gallstones and also multiple benign cysts in his liver. Common bile duct measures 5mm. He has been on a strict low fat diet and has been okay since. He has a past medical history of heart surgery in 2014 and he is on Aspirin.*
>
> *We had a long conversation about going ahead with an operation to remove his gall bladder. I did explain the risks of bleeding, infection, damage to the bowel, liver and the common bile duct. I also explained to him the need to do this operation open, taking into consideration his previous laparotomy. [Patient A] is very keen to proceed with surgery and I will put his name on a waiting list and will expect to see him in theatre in due course.'*

37. The Tribunal considered Patient A's oral evidence to be consistent with his witness statements and gave it weight. Patient A told the Tribunal he *'remembered very clearly'* his two consultations with Dr Damas and was *'puzzled'* and *'very surprised'* when he was told after his surgery that the surgery had been started by keyhole, not open.

38. The Tribunal discussed the natural meaning of the word 'obtained' in this context. The Cambridge Dictionary defines to 'obtain' as to: *'get something, especially by asking for it'…* Thus, Dr Damas could ask Dr B, who was his Senior House Officer (SHO), to get or obtain Patient A's signature on the consent form, to confirm that he was still, on 25 September, agreeable to having the open procedure he had previously been advised by Dr Damas to

have, to remove his gallbladder. The Tribunal determined that the GMC had shown that it was more likely than not that Dr Damas obtained Patient A's signed consent to undergo a cholecystectomy by the open approach, even if he had delegated the responsibility of obtaining the signature on the form to Dr B. The Tribunal therefore found paragraph 1 of the Allegation proved.

Paragraph 2

39. The Tribunal first considered whether Dr Damas had commenced the procedure by laparoscopic approach. If the GMC proved that element of the allegation, then the Tribunal would be required to consider whether he had obtained consent for keyhole surgery before embarking on it. In relation to how the surgery started the Tribunal took account of Dr B's witness statement:

> *'I do recall assisting Dr Damas with the operation and I can recall that the operation began laparoscopically and was converted to an open procedure due to difficulties, but I cannot recall exactly why that change happened.'*

40. The Tribunal also took account of the Trust operating note dated 25 September 2018. This note appears to have been signed by Dr Damas. Under the heading Operation/Procedure it says:

> *'Laparoscopy converted to open cholecystectomy.'*

41. As to the scope of consent given, the Tribunal took account of the evidence of Patient A; key points are quoted above. If Dr Damas had instructed counsel, or attended his hearing, he would have had opportunity to cross-examine Patient A and/or his wife, but Dr Damas put no questions to either witness. The Tribunal asked Patient A questions, so it may be said that his oral evidence was partially tested.

42. Counsel for the GMC submitted that the evidence from Patient A was unchallenged and should be accepted by the Tribunal to find as fact that, on 25 September 2018, Dr Damas obtained Patient A's consent for a cholecystectomy by open approach but failed to obtain consent to undertake, or attempt, a laparoscopic approach. Applying a similar natural definition of 'obtained' as discussed above, the Tribunal considered that signed consent to surgery could be obtained by Dr Damas asking his SHO to request Patient A to sign a form confirming his consent to an operation discussed at two earlier appointments with Dr Damas.

43. The Tribunal considered extracts from the 'complaint file' provided by the Trust to the GMC. It records Dr Damas' response to allegations by Patient A:

> *'Dr Damas states that he had a long conversation with [Patient A] in June 2018 about proceeding with the operation to remove the gallbladder during which he explained the very high probability of the operation being converted to open rather than laparoscopically.'*

44. The Tribunal also took account of email correspondence from Dr Damas responding to the referral to the GMC by Patient A:

> *'At that time we had a long conversation about going ahead with an operation to remove his gall bladder, taking into consideration his previous surgery and also the fact that he was on Aspirin the risk was high. I did explain… the risk of bleeding, infection and also the possible injury to the bowel. It was also explained to [Patient A] and documented the very high probability of the operation being converted to open rather than laparoscopic but [Patient A] was still happy to proceed with surgery, he was therefore added to my waiting list. The operation was performed on 25 September 2018 and almost immediately after the operation had been started, we realised that it would not be possible to perform the operation laparoscopically and a decision to convert the operation to open was made immediately…*
> *From a technical point of view, it was a complicated operation full of adhesions around the abdominal cavity and also around the gallbladder and Calot triangle. The gallbladder was removed, however during the procedure, either laparoscopic or open, an injury was caused to the small bowel but not identified by myself or my assistant during the procedure. This complication is described in the literature with a rate below 1%. Five days after the operation, [Patient A] was readmitted to the hospital with an acute abdominal pain and he was immediately seen by one of my colleagues. At the time a CT scan was performed, and he was readmitted for surgery to repair the bowel injury. [Patient A] was followed up and recovered from the second operation.'*

45. The Tribunal considered a letter Dr Damas had written in the complaint file:

> *'There is a great benefit of doing the cholecystectomy laparoscopically, including in patients with previous laparotomies, not just in terms of recovery time but also in terms of post-op pain control. The second point that I wish to highlight is the fact that the operation was done by myself. The decision to start the operation laparoscopically and then to convert it to open was decided while the patient was in theatre, it was my clinical decision at that time. I was responsible for all the written correspondence,*

consent forms, and all the information that was given to [Patient A] prior to his surgery.'

46. In correspondence with the Trust and GMC, Dr Damas sought to justify attempting the procedure laparoscopically. He has never sought to deny that he started operating laparoscopically, only to assert that he had the necessary informed consent from Patient A. The Trust's response to Patient A on 14 August 2019 said:

'I am sorry for your recollection of the communication with you regarding keyhole (laparoscopic) versus open surgery is at odds with the account from Mr Damas. I am advised by Mr Damas that he had a verbal conversation with you just before your surgery when he advised you that he would attempt to perform a laparoscopy but there was a high probability that the procedure would need to be converted to open surgery'.

The Tribunal considered that this letter was likely to have been drafted to reflect Dr Damas' account of events. No weight could be given to this response from the Trust, as it uncritically adopts Dr Damas' version of events. The Trust appears not to have asked the anaesthetist or any other clinician likely to have been present at relevant times on 25 September 2018. Similarly, the GMC has not adduced evidence from others present, except the SHO.

47. The Tribunal took account of expert evidence from Mr C. In answer to questions from the Tribunal, Mr C said that Patient A's injury was likely to have been caused by attempting surgery laparoscopically. This was because the injury at the site of the abscess, was low down on the right side of the abdomen, indicating that a procedure had been attempted laparoscopically. Mr C opined that the injury to Patient A was '*ten times*' more likely to have been caused laparoscopically than by way of an open procedure.

48. Also in answer to Tribunal questions, Mr C said that he was '*absolutely certain that [Patient A] went into surgery expecting the open procedure*' when taking account of the inconsistent consent forms provided by the GMC for consideration. The Tribunal had to make its own findings of fact and based its conclusions primarily on evidence from Patient A in the context of uncontested documentary evidence. The Tribunal concluded that the GMC had proved to the civil standard, first, that Dr Damas commenced the procedure on 25 September 2018 by laparoscopic approach and, second, that Dr Damas did not obtain further consent to 'keyhole' surgery from Patient A before starting to operate laparoscopically. The Tribunal found paragraph 2 proved on a balance of probabilities.

<u>Paragraph 3(a) and 3(b)</u>

49. To prove that Dr Damas did as alleged at paragraph 3 of the Allegation, the GMC had to establish both that he added the words 'laparoscopy' and 'laparotomy' and also that he did so *after* Patient A signed the consent form. In his response to the GMC Dr Damas appeared to accept that he added words to the consent form after it had been signed by Patient A:

> *'The problem with this complaint is related with the consent form. It was altered by me after sign by the SHO but it was altered in front of the patient and everything was explained. Altering or adding to a consent form is acceptable, but going forwards it is probably worth to sign me & the patient initialling any alteration, or starting again.'*

50. Dr Damas does not deny adding words to the consent form. The Tribunal considered that his response (above) amounts to an acceptance by Dr Damas that he added the extra words 'laparoscopy' and 'laparotomy' as these are the only words in different handwriting on the consent form. In response to a complaints co-ordinator at the Trust, Dr Damas said:

> '*The fact that there are two consent forms, one of them with a spelling mistake corrected by me in front of the patient explaining again to him that I would try to do the operation laparoscopically first can justify the fact that there are two consent forms.'*

51. Although there was a missing 'a' in the word *'laprotomy',* there is no apparent attempt to amend it to *'laparotomy',* so the Tribunal did not accept that Dr Damas had 'corrected' a minor typographical error. His explanation for adding words to the consent form was implausible and not supported by any document or other witness.

52. The clear evidence of Patient A was that he did not see Dr Damas alter the consent form at any point and the Tribunal accepted this as credible in the context of all other evidence. Dr B said that the standard practice when changing a consent form once the patient has consented is that everyone would re-sign the consent form or generate a new form. In oral evidence Mr C described Dr Damas' account on this issue as '*nonsense*'.

53. The Tribunal considered that the GMC had proved that Dr Damas added the words 'laparoscopy' and 'laparotomy' *after* Patient A had signed the consent form. Dr Damas' account of gaining informed consent before surgery from Patient A was not corroborated or supported by any other witness or documentary evidence, so the Tribunal did not give it weight. Where their accounts differed on key disputed issues, the Tribunal preferred the account of Patient A to that of Dr Damas as it was more plausible and supported by other

evidence. The Tribunal determined that the GMC had discharged the burden on it to prove both paragraphs 3(a) and 3(b).

Paragraph 4(a) and 4(b)

54. In the letter he wrote to Patient A's GP on 26 June 2018, Dr Damas made his intentions very clear. He tells the GP that the procedure needed to be done by way of open surgery, due to the risks of keyhole or laparoscopic surgery:

> *'We had a long conversation about going ahead with an operation to remove his gall bladder. I did explain the risks of bleeding, infection, damage to the bowel, liver and the common bile duct. I also explained to him the need to do this operation open, taking into consideration his previous laparotomy. He is very keen to proceed with surgery and I will put his name on a waiting list and will expect to see him in theatre in due course.'*

55. This letter provides strong contemporaneous evidence that Dr Damas knew Patient A had been advised of the risks of keyhole surgery, advised to have open surgery, and that Patient A had then consented to the approach his surgeon had unequivocally recommended. It may be inferred that Dr Damas knew that Patient A had not consented to the procedure being carried out by the laparoscopic approach, because Dr Damas had advised against keyhole surgery.

56. In addition, the consistent plausible account of Patient A is that he was advised to have the procedure by open surgery, because keyhole surgery was risky in the context of his medical history; that he took this advice, that he did not change his mind at any point; and that Dr Damas did not speak to him about widening the scope of his consent just before his operation on 25 September 2018. Patient A gave evidence of being surprised when Dr Damas told him he had attempted laparoscopic surgery.

57. The Tribunal concluded that Dr Damas was aware that Patient A had only given consent to the procedure being carried out by open surgery. This was the limit of the scope of Patient A's consent. The Tribunal found as fact that Patient A had not consented to keyhole, or laparoscopic, surgery and considered that Dr Damas was more likely than not to have been fully aware of this fact, as he clearly articulated the true position in his letter to the GP.

58. The Tribunal considered that the GMC had proved Dr Damas altered the consent form, by adding words, with a view to indicating, falsely, that Patient A had given consent to

his procedure being done by way of keyhole surgery, with a possibility of conversion to open surgery, when Patient A had only consented to open surgery. The Tribunal found that the GMC had proved both paragraph 4(a) and 4(b).

Paragraph 5

59. The Tribunal gave weight to Dr Damas' good character, both as to the likely veracity of his account of events to the Trust and GMC, as well as in assessing the likelihood that he would act as alleged by the GMC. The Tribunal applied the test for dishonesty in *Ivey 2017*.

60. First the Tribunal ascertained the state of Dr Damas' knowledge or belief as to the facts, as set out above. Dr Damas knew that Patient A had not consented to keyhole surgery, but he amended the consent form to indicate that Patient A had consented to keyhole, or laparoscopic surgery. The Tribunal then had to consider whether Dr Damas' retrospective amendment of the consent form was honest or dishonest by the standards of ordinary decent people.

61. Except in an emergency, surgeons cannot lawfully operate without consent from patients. In this context, the Tribunal concluded that Dr Damas had probably sought to conceal the fact that he had performed keyhole surgery without the necessary consent. Most people would regard Dr Damas' amendment of the consent form to misrepresent the scope of consent from Patient A as dishonest. The Tribunal determined that the GMC had discharged the burden on it to show that Dr Damas was more likely than not to have been dishonest when he amended the consent form. The Tribunal found paragraph 5 found proved on a balance of probabilities.

The Tribunal's Overall Determination on the Facts

62. The Tribunal has determined the facts as follows:

1. On 25 September 2018 you obtained Patient A's signed consent to undergo a cholecystectomy ('the Procedure') by the open approach. **Determined and found proved**

2. On 25 September 2018 without obtaining further prior consent from Patient A, you commenced the Procedure by laparoscopic approach. **Determined and found proved**

3. On a date and at a time unknown but after the consent form for the Procedure was presented to and signed by Patient A, you amended the master copy of the consent form in that you:

a. added the word 'laparoscopy' in the 'Name of proposed procedure or course' section; **Determined and found proved**

b. added the word 'laparotomy' in the 'other procedure (please specify)' section. **Determined and found proved**

4. When you acted in the manner described at paragraph 3, you knew that:

a. Patient A had consented to the Procedure being carried out by the open approach; **Determined and found proved**

b. Patient A had not consented to the Procedure being carried out by the laparoscopic approach; **Determined and found proved**

5. Your conduct at paragraph 3 was dishonest by reason of paragraph 4**. Determined and found proved**

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct. **To be determined**

Determination on Impairment - 18/08/2023

63. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts found proved above, Dr Carlos Filipe Gomes de Sanches Damas' fitness to practise is impaired by reason of misconduct.

The Evidence

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

Submissions

65. Ms Ceri Widdett, Counsel for the GMC, provided written and verbal submissions. Ms Widdett reminded the Tribunal that, at this stage of proceedings, there is no burden or standard of proof and the decision on impairment is a matter for the Tribunal's judgement alone. In approaching the decision, the Tribunal should be mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct, which was serious; and if so, whether the finding of serious misconduct could lead to a finding of impairment.

66. Ms Widdett referred to the Tribunal's decision on facts. Dr Damas was found (a) to have performed surgery on Patient A without the necessary consent, and (b) to have been dishonest in amending the consent form. Ms Widdett submitted that the Tribunal should

identify this as serious misconduct, to uphold professional standards and to maintain public confidence in doctors, as required by the overarching objective in the Medical Act 1983.

67. Ms Widdett relied on principles in *GMC v Meadow [2006] EWCA Civ 1390* and submitted that Dr Damas' misconduct had crossed the threshold in *Meadow* to be deemed 'serious'. Dr Damas performed a major operation without the requisite consent and then lied to cover this up.

68. Ms Widdett submitted that Dr Damas had 'added insult to injury' by lying to conceal his failure to obtain consent for keyhole surgery and continued to misrepresent the position throughout the Trust investigation. Members of the public rightly expect doctors to be honest and to obtain informed consent; this is central to maintaining public confidence in doctors and the medical profession. The GMC is concerned that Dr Damas' actions have undermined that confidence. Other doctors would regard his actions as 'deplorable'.

69. Ms Widdett submitted that Dr Damas' conduct represented a serious departure from *Good Medical Practice* (2013, as amended) (*GMP*). Relevant paragraphs include the following:

55: 'You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should (a) put matters right (if that is possible), (b) offer an apology, and (c) explain fully and promptly what has happened and the likely short-term and long-term effects'

61: 'You must respond promptly, fully and honestly to complaints and apologise when appropriate…

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

68: 'You must be honest and trustworthy in all your communication with patients and colleagues…'

71: 'You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading: (a) You must take reasonable steps to check the information is correct, and (b) You must not deliberately leave out relevant information.'

70. Ms Widdett referred the Tribunal to GMC guidance, *Decision Making and Consent*, issued in November 2020. Although this was issued after the time of the Allegation, it reflects established principles:

'Consent is a fundamental legal and ethical principle…'

71. Ms Widdett also relied on the test in *CHRE v NMC and Grant [2011] EWHC 927*. The GMC is concerned that Dr Damas had been dishonest, breached fundamental tenet/s of medicine and thus brought the profession into disrepute, and that he has potential to do so again, in breach of (b) (c) and (d) below.

a) …

b) Whether the registrant has in the past brought and/or is liable in the future to bring the profession into disrepute;

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

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

72. Ms Widdett submitted that the Tribunal has no evidence that Dr Damas would act any differently in future, adding that Dr Damas appears to lack insight into the seriousness of his misconduct. Ms Widdett submitted that Dr Damas had failed to make any admissions or to take responsibility for his actions.

73. Also, that Dr Damas had not reflected on his actions, the impact of his actions on colleagues, Patient A, his relatives, the public and the reputation of the profession. In short, Dr Damas had not demonstrated that he appreciates the gravity and consequences of his actions. He has not shown any attempt to remediate his misconduct in operating without the necessary consent, or subsequent dishonesty.

74. In conclusion, Ms Widdett said that a finding of impairment is necessary to satisfy the statutory overarching objective, specifically to promote and maintain public confidence in the medical profession and promote and maintain proper professional standards and conduct for members of the profession.

Advice from the LQC and Approach by Tribunal

75. The LQC said that the word misconduct in the Medical Act 1983 connotes a serious breach indicating that a doctor's fitness to practise is impaired. The Tribunal should consider its factual findings in the context of Dr Damas' whole practice: *Calhaem v GMC [2007] EWHC 2606.*

76. In *Remedy UK v GMC [2010] EWHC 1245* the High Court said that misconduct is of two principal kinds. First, misconduct going to fitness to practise in the exercise of professional medical practice. Second, morally culpable or otherwise disgraceful conduct, outside or within professional practice. Conduct falls into the second category if it is dishonorable or attracts condemnation. That may be sufficient to bring the profession of medicine into

disrepute and it does not matter whether or not directly related to the exercise of professional skills.

77. Impaired is an ordinary word, not defined in the Medical Act 1983. At the impairment stage, there is no burden or standard of proof. It is a question of judgment for the Tribunal. Impairment may be based on past actions or a continuing situation, but it is to be decided at the time of the hearing. To do this the Tribunal must look forward, taking account of any changes in practice, conduct or attitude since the relevant time. Personal mitigation has less relevance, but any effort to accept and correct remediable errors should be considered.

78. In determining impairment the Tribunal must assess, as required by *Grant*, whether Dr Damas' actions or omissions indicate any risk of harm, breach of a fundamental tenet of the medical profession, bringing it into disrepute, or dishonesty, whether in the past or the risk of repetition in the future.

79. The need to maintain public confidence in the medical profession or declare standards of behavior may mean that a doctor's fitness to practise is impaired by reason of certain acts of misconduct of themselves. A finding of impairment may be necessary to reaffirm the standard of conduct expected of doctors: *Yeong v GMC [2009] EWHC 1923.*

80. In some cases a rejected defence may be relevant to insight and thus risk, but it is permissible to deny an allegation of dishonesty: a doctor has a right to a fair hearing: *Sawati v GMC [2022] EWHC 283.* However, the Tribunal will be aware that Dr Damas has not provided a formal statement or given evidence after affirmation.

81. The LQC reminded the Tribunal of the tripartite public interest and the need for a proper balancing exercise of all three elements of the public interest test: *Chaudhury [2017] EWHC 2561.* The Tribunal should decide this case on its merits.

82. 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.

83. 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, that the misconduct was serious and then whether the finding of that misconduct which was serious could lead to a finding of impairment.

84. The Tribunal must determine whether Dr Damas' fitness to practise is impaired today, taking account of his conduct at the time of events and any relevant factors since then, such as insight, remediation and any likelihood of repetition.

The Tribunal's Determination

85. The Tribunal took account of all documents reflecting Dr Damas' account of events to the Trust or GMC, especially where relevant to remorse, insight and risk of repetition. On 27 January 2020 he wrote to the Trust Complaints Coordinator:

'I would like to have this opportunity to send feedback to Patient A explaining to him that it was always my intention to do this procedure laparoscopically. The operation that we booked was very difficult to perform laparoscopically. So I did explain to him the high probability to do the operation open. The fact that there are two consent forms, one of them with a spelling mistake corrected by me in front of the patient explaining again to him that I would try to do the operation laparoscopically can justify the fact that there are two consent forms.

However, I would like to take full responsibility for the fact that I could not make myself clear that I would try to do the operation laparoscopically first. I understand that this is entirely my fault, and also the fact that the correspondence letters do not explain the intention to try this operation laparoscopically first.

There is a great benefit of doing the cholecystectomy laparoscopically, including in patients with previous laparotomies, not just in terms of recovery time but also in terms of post-op pain control. The second point that I wish to highlight is the fact that the operation was done by myself. The decision to start the operation laparoscopically and then to convert it to open was decided while the patient was in theatre, it was my clinical decision at that time. I am responsible for all the written correspondence, consent forms, and all the information that was given to Patient A prior to his surgery.

I did learn from the mistakes of this case, the fact that the information was not clear and he did not understand that we were going to try laparoscopically first, like we do in almost every single patient, was a fault that I consider myself responsible for. I am truly sorry for what happen. I will make sure this does not happen again.'

Misconduct

86. The Tribunal considered that Dr Damas' conduct fell short of the standard expected for a medical practitioner, as members of the public expect doctors to behave with honesty and integrity. Before operating a surgeon is required to obtain informed consent. Other doctors would condemn any failure to do so, as would the wider public. Although Dr Damas wrote to the Trust to say he was sorry about what had happened, he has not accepted responsibility for undertaking surgery outside the scope of Patient A's consent. Most people would condemn the attempt by Dr Damas to conceal this by retrospective amendment of a consent form.

87. The Tribunal considered Dr Damas' actions to amount to serious misconduct in a professional context. If known about, his misconduct would bring the profession of medicine into disrepute.

Impairment

88. The Tribunal, having found that the facts found proved amounted to serious misconduct, went on to consider whether, as a result of that misconduct, Dr Damas' fitness to practise is currently impaired.

89. Dr Damas did not provide the Tribunal with any evidence of insight or changes in practice, conduct or attitude since the relevant time. He does not appear to have made any effort to accept errors made. The Tribunal was concerned that Dr Damas sought to misrepresent the position in relation to consent both to Patient A and the Trust.

90. In determining impairment the Tribunal took account of principles in *Grant*. The Tribunal considered that Dr Damas had breached a fundamental tenet of the medical profession by acting dishonestly. His actions had potential to bring the profession brought into disrepute.

91. Although he may regret the fact that surgery did not go well, Dr Damas has not expressed remorse for the impact on Patient A of his alteration of the consent form. The Tribunal had no real evidence of insight into the consequences of his dishonest behaviour and thus cannot be satisfied that necessary steps have been taken to minimize the risk of repetition. Without insight, successful remediation is unlikely. Dr Damas did not produce any evidence of reflection or continuing professional development in relevant areas such as consent or ethics.

92. The Tribunal accepted the GMC's submission that paragraphs 55, 61, 65 and 68 of GMP are engaged in this case. The Tribunal also considered that Dr Damas did not act in accordance with paragraph 17 of GMP:

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.

93. The Tribunal determined that Dr Damas' current fitness to practise is impaired by reason of his serious misconduct. A finding of impairment is necessary to maintain public confidence in doctors, and to uphold professional standards and conduct for members of the medical profession.

Determination on Sanction - 23/08/2023

94. Having determined that Dr Damas' fitness to practise is impaired by reason of misconduct, the Tribunal must now decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

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

Submissions

96. On behalf of the GMC, Ms Widdett acknowledged that the decision on Sanction is a matter for the Tribunal's independent judgement. Ms Widdett also said the Tribunal should consider all options, starting with the least serious.

97. Dr Damas has been found to have breached paragraphs 55, 61, 65, 68, and 17 of *Good Medical Practice* (2013, as amended) (*GMP*). The Tribunal also found that Dr Damas did not provide any evidence of insight or changes in practice, conduct or attitude since the relevant time. Ms Widdett submitted that the Tribunal should take account of the following in its decision, applying relevant paragraphs of the *Sanctions Guidance* (2020) (SG):

- Dr Damas lacks the timely development of insight: SG 52(a) & (c).
- Dr Damas is unwilling to engage: SG 97(e).
- The Tribunal cannot be satisfied that he has insight and does not pose a risk of repeating his behaviour SG 97(g).
- There has been a serious departure from the principles of GMP which is fundamentally incompatible with Dr Damas being a doctor: SG 109(a).
- There has been a deliberate disregard for the principles of GMP: SG 109(b).
- There has been an abuse of trust: SG 109(d).
- Dr Damas has been dishonest: SG109(h).
- His dishonesty has been persistent and covered up: SG 120- 128.
- Dr Damas has put his own interests before those of Patient A: SG109(i).
- There is a persistent lack of insight into the seriousness or consequences of his actions: SG109(j).
- Erasure is necessary to maintain public confidence in the profession: SG 108.

98. Ms Widdett said there were no exceptional circumstances that would justify no action being taken. Conditions would not be appropriate to deal with the serious nature of this misconduct, nor would they be workable or measurable. An order of suspension would not be appropriate in view of Dr Damas' apparent lack of insight, failure to engage or demonstrate remediation.

99. Ms Widdett submitted that the Tribunal should erase Dr Damas' name from the medical register to declare/uphold standards and to maintain public confidence in the medical profession. Erasure would be appropriate and proportionate, as it is necessary to satisfy limbs two and three of the overarching objective in the Medical Act 1983.

Advice from the LQC

100. At the Sanction stage of proceedings there is no burden or standard of proof and the decision on sanction is a matter for the Tribunal's judgment alone. GMP sets out standards expected of doctors throughout their careers, irrespective of their area of practice. Where

misconduct is grave or there has been a serious departure from professional standards, erasure from the register may be the only means of protecting patients or maintaining public confidence in the profession. If possible, a balance should be struck between the doctor's interest and the public interest, but this cannot always be achieved.

101. *Raschid and Fatnani v GMC [2007] 1 WLR 1915* says that the Tribunal is centrally concerned with the reputation or standing of the profession, rather than the punishment of the doctor, despite the fact that sanctions may have a punitive, even a devastating, effect.

102. The aim of SG is to promote consistency and transparency in decisions, but it is intended to be flexible and is not comprehensive or specific in describing all circumstances. Although a Tribunal need not adhere to SG, it should have proper regard to and apply it: *Bramhall [2021] EWHC 2109.* If departing from the SG, a Tribunal has a duty to state clear, substantial and specific reasons.

103. In *PSA v GMC and Doree [2017] EWCA Civ 319* it was confirmed that a tribunal may reasonably find that a registrant has shown insight or remorse without hearing oral evidence to demonstrate it, even if it has rejected the doctor's evidence on some or all of the allegations. Whether a doctor has shown insight into their misconduct, and how much, are classically matters of fact and judgement for the professional Tribunal in light of the evidence before it. In assessing a doctor's insight the Tribunal must weigh all the relevant evidence, including any oral or written submissions from the doctor. This may include testimonial evidence as well as any objective evidence of remediation.

104. In reaching its decision, the Tribunal will consider relevant parts of the SG cited by counsel. It will bear in mind that the main reason for imposing sanctions is to protect the public, taking account of the overarching objective in the Medical Act 1983 referred to in the determination on impairment.

105. In *Kimmance v GMC [2016] EWHC 1808* the court said that, when demonstrating insight and remediation, a doctor 'who has done wrong has to look at his or her conduct with a self-critical eye, acknowledge fault, say sorry and convince a panel that there is a real reason to believe he or she has learned from experience.'

106. A rejected defence may be relevant to insight and thus risk, but it is permissible to deny an allegation of dishonesty; a doctor has a right to a fair hearing: *Sawati v GMC [2022] EWHC 283.*

107. In deciding what sanction, if any, to impose the Tribunal will consider the sanctions available, starting with the least restrictive. It will also take account of the principle of proportionality and the need to weigh the interests of the public against those of the doctor. Just because there is an absence of independent or objective evidence in relation to a potentially mitigating factor, it should not automatically be treated as an aggravating factor instead: *Al Nageim v GMC [2021] EWHC 877.*

108. Erasure for dishonesty is not automatic, its nature and extent must be evaluated.

The Tribunal's Determination on Sanction

109. The decision as to the appropriate sanction to impose, if any, is a matter for this Tribunal exercising its own judgement. In reaching its decision, the Tribunal has taken account of the SG and GMP. The purpose of a sanction is to protect patients and the wider public interest, but it may have a punitive effect.

110. The Tribunal was aware that there is a public interest in facilitating the safe return to practice of an otherwise competent doctor, where feasible. It also took account of the fact that there is a spectrum of dishonesty.

111. The Tribunal considered the least restrictive option first, then each available sanction in ascending order of severity. In its deliberations, the Tribunal applied the principle of proportionality, balancing Dr Damas' interests with the wider public interest. It has taken account of all relevant evidence, as well as its decisions on facts and impairment, above.

112. Dr Damas qualified over two decades ago. He has no convictions (or cautions) or adverse regulatory history known to the GMC. The Tribunal has found proved the Allegation that he operated beyond the scope of consent obtained and dishonestly amended a consent form. The Tribunal is unaware of any subsequent misconduct.

113. Dr Damas has not given evidence or explained how he now views his actions. The Tribunal must take relevant background and context into account, as well as any aggravating and mitigating factors identified.

Aggravating and mitigating factors

114. The Tribunal considered paragraphs 51 and 52 of the SG.

51 It is important for tribunals to consider insight, or lack of, when determining sanctions…

52 A doctor is likely to lack insight if they:
(a) refuse to apologise or accept their mistakes
(b) …
(c) do not demonstrate the timely development of insight.
(d)…

Dr Damas has not accepted mistakes in relation to performing keyhole surgery without the requisite consent, nor as to his retrospective amendment of the consent form.

115. On 27 January 2020 Dr Damas wrote to the Trust Complaints Coordinator. He apologised for not being 'clear' enough in his communications with Patient A or his GP:

'However, I would like to take full responsibility for the fact that I could not make myself clear that I would try to do the operation laparoscopically first. I understand that this is entirely my fault, and also the fact that the correspondence letters do not explain the intention to try this operation laparoscopically first.

There is a great benefit of doing the cholecystectomy laparoscopically, including in patients with previous laparotomies, not just in terms of recovery time but also in terms of post-op pain control. The second point that I wish to highlight is the fact that the operation was done by myself. The decision to start the operation laparoscopically and then to convert it to open was decided while the patient was in theatre, it was my clinical decision at that time. I am responsible for all the written correspondence, consent forms, and all the information that was given to Patient A prior to his surgery.

I did learn from the mistakes of this case, the fact that the information was not clear and he did not understand that we were going to try laparoscopically first, like we do in almost every single patient, was a fault that I consider myself responsible for. I am truly sorry for what happen. I will make sure this does not happen again.'

116. The Tribunal accepted that Dr Damas is 'truly sorry' in a general sense for how he treated Patient A. However, Dr Damas has not taken responsibility for the specific misconduct found proved: adopting the laparoscopic approach without consent and dishonestly amending the consent form.

117. The Tribunal considered that Dr Damas has not demonstrated the timely development of insight: 52(c) of SG. He did not attend this Tribunal or provide a reflective statement and the Tribunal had no other evidence of insight.

118. The Tribunal also took account of paragraphs 55(b) and 55(d) of the SG.

55 Aggravating factors that are likely to lead the tribunal to consider taking more serious action include:
(a)…
(b) a failure to work collaboratively with colleagues
(c) …
(d) abuse of professional position
(i) …]

119. Dr Damas could be said to have abused the trust placed in him as a doctor when he gave an untrue account of events to his employer. The SG makes it clear that abuse of professional position is particularly serious when it involves vulnerable patients or predatory behaviour; this was not alleged here. Retrospective amendment of any clinical record could mislead colleagues; it is not cooperative or collaborative. However, there was no suggestion of discrimination, harassment or failure to work cooperatively as part of the clinical team.

The Tribunal did not therefore consider the criteria in paragraph 55 of the SG to be satisfied, taking account of paragraphs 136 to 138 of the SG.

120. In determining the appropriate sanction to impose, the Tribunal gave weight to Dr Damas' failure to demonstrate the timely development of insight: SG 52(c). This could be described as an aggravating factor.

121. The Tribunal took account of the lapse of time since these events took place as a mitigating factor: paragraph 25 of the SG. No others were identified.

25 The following are examples of mitigating factors
(a) - (d)…
(e) Lapse of time since an incident occurred.

122. The Tribunal considered the fact that Dr Damas was of good character to be important. He had worked as a doctor since 2002 without any regulatory issues.

No action

123. In reaching its decision as to the appropriate sanction, if any, to impose in this case, the Tribunal first considered whether to conclude by taking no action.

124. The Tribunal considered that there were no exceptional circumstances to justify taking no action. A sanction was necessary to uphold standards and maintain public confidence in the medical profession.

Conditions

125. The Tribunal next considered whether it would be appropriate to impose conditions on Dr Damas' registration. Any conditions imposed should be appropriate, workable and proportionate. The Tribunal took account of paragraphs 79, 81, 82 and 84(d) of the SG:

79 Conditions restrict a doctor's practice or require them to do something…

81 Conditions might be most appropriate in cases:
- *(a) involving the doctor's health*
- *(b) involving issues around the doctor's performance*
- *(c) where there is evidence of shortcomings in a specific area or areas of the doctor's practice*
- *(d) where a doctor lacks the necessary knowledge of English to practise medicine without direct supervision.*

82 Conditions are likely to be workable where:
- *(a) the doctor has insight*

(b) a period of retraining and/or supervision is likely to be the most appropriate way of addressing any findings
(c) the tribunal is satisfied the doctor will comply with them
(d) the doctor has the potential to respond positively to remediation, or retraining, or to their work being supervised.

84 Depending on the type of case… some or all of the following factors being present … would indicate that conditions may be appropriate:
(a)…
(b)…
(c)…
(d) willing to be open and honest with patients if things go wrong.

126. The Tribunal did not consider that conditions would be appropriate in view of the seriousness of Dr Damas' misconduct. He was not open or honest with Patient A. No conditions would be appropriate or sufficient to uphold standards or to maintain public confidence in the profession.

Suspension

127. The Tribunal considered whether a period of suspension would be sufficient to maintain public confidence in doctors and uphold professional standards. It took account of the following paragraphs of the SG:

91 Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor…

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…

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.

97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.

(a) A serious breach of GMP, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any

sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.
(b)…
(c)…
(d)…
(e) No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.
(f) No evidence of repetition of similar behaviour since incident.
(g) The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.

128. Although there have been no previous unsuccessful attempts to engage (as there is no prior regulatory history) Dr Damas did not provide evidence to or attend this Tribunal. Dr Damas has not explained why he did what he did, or how he now sees his actions in 2018.

129. Dr Damas has not provided evidence of insight or remediation, nor sufficient acknowledgement of fault. However, he has expressed regret and a general intention to avoid repetition: *'I am truly sorry for what happen. I will make sure this does not happen again.'* There have been no subsequent allegations.

130. As he is not specific in his apology, this cannot be interpreted as evidence of remorse for his dishonesty. Dr Damas has not shown that he recognises the seriousness of his actions or consequences for Patient A, colleagues or the reputation of the profession.

131. The Tribunal considered if erasure would be the most appropriate sanction to impose. It considered the following paragraphs from the SG:

109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).

(a) A particularly serious departure from the principles set out in GMP where the behaviour is fundamentally incompatible with being a doctor.
(b) A deliberate or reckless disregard for the principles set out in GMP…
(c) ….
(d) …
(e) …
(f) …
(g) ….
(h) Dishonesty, especially where persistent and/or covered up
(i) Putting their own interests before those of their patients
(j) Persistent lack of insight into the seriousness of their actions or the consequences.

125 Examples of dishonesty in professional practice could include:

(a)…
(b) falsifying or improperly amending patient records

132. The Tribunal considered the amended consent form. Dr Damas made no attempt to reproduce the handwriting of the SHO who initially went through the form with Patient A. Dr Damas' amendment of the consent form did not appear to have been premeditated, as it seemed to be an unsophisticated (or panic) revision.

133. Dr Damas did not tell the truth about his actions to the Trust, but there was no evidence of any previous or subsequent dishonesty. The Tribunal considered that Dr Damas' actions had breached principles of medical ethics in relation to consent and honesty, reflected in GMP. However, in the context of a long career in medicine and no other regulatory breaches, the Tribunal did not conclude that his actions amounted to behaviour that is fundamentally incompatible with being a doctor.

134. Dr Damas retrospectively amended a consent form on one occasion and did not tell the truth to his employer when questioned. Dr Damas put his own interests before those of Patient A when he misrepresented events to the Trust. His dishonesty could be described as ongoing during this time, but there is no evidence of such an episode being repeated.

135. The Tribunal took account of the public interest in facilitating the safe return to practice of an otherwise competent doctor, where feasible. It also took account of the fact that there is a spectrum of dishonesty. In this case Dr Damas did not seek to make any financial gain. The Tribunal considered that, while reprehensible, Dr Damas' actions were not at the most serious end of the spectrum of dishonesty.

136. Although the decision on sanction was finely balanced, the Tribunal concluded that a lengthy suspension was the most appropriate and proportionate sanction to deal with a single episode of serious misconduct by a doctor with an otherwise good record. Dr Damas now has opportunity to reflect on his misconduct and likely consequences for everyone concerned, as well as damage to the reputation of the medical profession.

137. The Tribunal determined therefore that an order of suspension was required to declare and uphold professional standards, as well as to maintain public confidence in the medical profession. It then had to determine the length of the suspension.

138. The Tribunal was satisfied that a 12-month suspension was necessary to mark the seriousness of Dr Damas' misconduct. This would provide more time to reflect on why he acted as he did and how to avoid repetition. Dr Damas could take steps to remediate and gain insight into the impact of his misconduct by way of professional development in the areas of consent and ethics.

139. The Tribunal sought to be proportionate in its decision making, taking account of the need to protect the public and wider public interest. It was important to impose an appropriate sanction to mark the severity of his misconduct. Accordingly, the Tribunal determined to suspend Dr Damas' registration for 12 months, the maximum time.

Review

140. The Tribunal directed a review of Dr Damas' case. A reviewing Tribunal will decide whether he may safely resume unrestricted practice after his suspension. It will consider the wider public interest as required by the overarching objective in the Medical Act 1983. A review hearing will convene shortly before the end of Dr Damas' suspension unless an early review is sought by the doctor or the GMC. At the review hearing, the onus will be on Dr Damas to demonstrate insight and remediation. Dr Damas may provide a reflective statement, testimonials, any evidence of professional development and such other information he relies on.

Determination on Immediate Order - 23/08/2023

141. Having determined to impose a 12-month suspension order on Dr Damas, the Tribunal had to consider, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order.

Submissions

142. Ms Widdett made no application on behalf of the GMC.

143. Dr Damas was not in attendance or represented and no submissions were made on his behalf.

The Tribunal's Determination

144. In reaching its decision, the Tribunal has exercised its own judgement, and has taken account of the principle of proportionality. The Tribunal has borne in mind that it may impose an immediate order where it is satisfied that it is necessary for the protection of members of the public or otherwise in the public interest or is in the best interests of the practitioner. It has also borne in mind the guidance given in paragraphs 172,173 and 178 of the Sanctions Guidance (November 2020 edition) ('the SG') which states:

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.*

145. The Tribunal determined that, given the seriousness with which it viewed Dr Damas misconduct, its findings on impairment and the sanction it has imposed, it is in the public interest to suspend his registration with immediate effect in order to uphold standards for doctors and maintain public confidence in the medical profession.

146. This means that Dr Damas' 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.

147. There is no interim order currently imposed on Dr Damas' registration.

148. That concludes the case.

ANNEX A – 16/08/2023

Determination: Service and proceeding in absence

149. Dr Gomes de Sanches Damas is neither present nor represented at this hearing.

150. Ms Widdett, Counsel, on behalf of the GMC, provided the Tribunal with documents regarding service of these proceedings on Dr Gomes de Sanches Damas. This included a copy of the GMC Notice of Allegation letter which was emailed and posted to Dr Gomes de Sanches Damas.

151. The Tribunal was given a copy of the Medical Practitioners Tribunal Service (MPTS) Notice of Hearing letter, dated 27 June 2023, which was emailed to the email address provided to the GMC. An email chasing a response was sent to the same address on 28 June 2023. No response was received by email. On 29 June 2023, the MPTS Notice of Hearing letter was issued to Dr Gomes de Sanches Damas' registered address. Royal Mail Track and Trace documentation again confirmed that the Notice of Hearing had been marked *'Recipient not at address. Gone away'*.

152. The Tribunal had regard to the service bundle provided by the GMC, as well as Ms Widdett's submissions. Having considered all of the evidence before it, the Tribunal determined that notice of the hearing had been served in accordance with Rules 20 and 40 of the General Medical Council (Fitness to Practise) Rules 2004 (as amended) ('the Rules') and paragraph 8 of Schedule 4 to the Medical Act 1983 (as amended).

Proceeding in Dr Gomes de Sanches Damas' absence

153. The Tribunal went on to consider whether it would be appropriate to proceed with this hearing in Dr Gomes de Sanches Damas' absence pursuant to Rule 31 of the Rules. The Tribunal was conscious that the discretion to proceed in the absence of a doctor should be exercised with appropriate care and caution, balancing the interests of the doctor with the wider public interest.

154. Ms Widdett submitted that Dr Damas, is aware of these proceedings and has chosen not to attend or instruct someone to attend on his behalf, and he's voluntarily absented himself and had very little contact with the GMC and there's no substantive response or evidence that's been adduced on his behalf.

155. Ms Widdett invited the Tribunal to proceed in Dr Damas absence. She submitted that all reasonable efforts had been made to serve notice of this hearing on Dr Damas. She submitted that there is not any evidence that an adjournment would secure Dr Damas' attendance.

156. The Tribunal balanced Dr Damas' interests with the public interest in deciding whether to proceed in his absence. It noted that Dr Damas had not engaged or expressed he wished to be in attendance. The Tribunal took account of fairness to Dr Damas, the GMC, the overarching objective, and the wider public interest. The Tribunal considered that the GMC had made all reasonable attempts to communicate with Dr Damas. It considered that delivery was attempted but was not successful. It noted that Dr Damas' had made no application for an adjournment and the Tribunal had not been provided any evidence of ill health.

157. Considering the need to protect the public, including the public interest in these matters, the Tribunal determined that, in accordance with Rule 31 of the Rules, it was in public interest to proceed with this hearing today in the absence of Dr Damas.