PUBLIC RECORD

Dates: 30/03/2026 - 14/04/2026

Doctor:	Dr Costantino DAVIDE
GMC reference number:	6100124
Primary medical qualification:	MD 1992 Universita degli Studi di Trieste

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

Summary of outcome

Conditions, 24 months.
Review hearing directed
Immediate order imposed

Tribunal:

Legally Qualified Chair	Mrs Claire Lindley
Lay Tribunal Member:	Mr Rob McKeon
Registrant Tribunal Member:	Dr Sarah Woodford

Tribunal Clerk:	Mr Laurence Millea – 30/03/2026 – 10/04/2026 Mrs Olivia Gamble – 13/04/2026 – 14/04/2026

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Robert Whittock, Counsel, instructed by RKM Law
GMC Representative:	Mr Alan Taylor, Counsel Mr Ged Doran, Counsel (14 April)

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts - 08/04/2026

1. The GMC record is that Dr Davide qualified in 1992. In 1995, he graduated in Plastic Reconstructive and Cosmetic Surgery from the University of Padua and in the same discipline from Carlos Chagas Post Graduation Institute in Rio de Janeiro, Brazil. Prior to the events which are the subject of the hearing, Dr Davide practised as a Consultant in the Special Surgical Pathology Institute and the Surgical Clinical Institute of the University of Trieste in Cattinara Hospital until 2002, when he moved to private practice. Dr Davide has worked as a plastic surgeon in various countries since then, commencing private practice in the UK in 2018.

2. At the time of the events, Dr Davide was practising as a Consultant Plastic Surgeon at a private company named Top Cosmetic Surgery UK Ltd.

3. It is alleged by the General Medical Council (GMC) that on 12 February 2022, Dr Davide failed to communicate to Patient A risks regarding a proposed procedure and failed to make adequate records.

4. The initial concerns were raised with the GMC on 10 September 2024 by Patient A who submitted a 'concerns form' with a summary attached, which it received on 13 September 2024.

The Outcome of Applications made during the Facts Stage

5. The Tribunal granted Dr Davide's application, made by Mr Whittock, Counsel, pursuant to Rule 34(1) of the GMC (Fitness to Practise Rules) 2004 as amended ('the Rules'),

to admit further evidence in the form of Patient A's unredacted medical records. The Tribunal's full decision on the application is included at Annex A.

6. The Tribunal granted the GMC's application, made by Mr Taylor, Counsel, pursuant to Rule 35(4), for Patient A to be anonymised throughout proceedings. This application was made to protect Patient A's confidentiality as matters heard related to her personal and sensitive medical history. This application was not opposed on behalf of Dr Davide.

7. The Tribunal granted the GMC's application, made pursuant to Rule 17(6) to amend the Allegation to withdraw paragraph 1(c). This application was not opposed on behalf of Dr Davide.

The Allegation and the Doctor's Response

8. The Allegation made against Dr Davide is as follows:

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

1. On 12 February 2022, you performed a bilateral blepharoplasty (upper and lower) and a facelift ('the Procedure') on Patient A and you failed to:

   a. obtain informed consent as Patient A was not informed of the risk of delayed wound healing; To be determined

   b. communicate to Patient A:

      i. that her body mass index ('BMI') was too high; To be determined

      ii. that she should stop smoking three weeks before the procedure; To be determined

      iii. that there was an increased risk of infection; To be determined

      iv. about her lung condition; To be determined

   c. ~~provide Patent A with post-operative follow-up every two weeks for a minimum of six to 12 months~~; Deleted under Rule 17(6)

d. adequately record:

i. the reasons for the proposed Procedure; To be determined

ii. the possible needs of pre-operative discussions and investigations; To be determined

iii. a treatment plan; To be determined

e. record, in the alternative, your actions as outlined in paragraphs:

i. 1a; To be determined

ii. 1b i-iv; To be determined

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

Witness Evidence

9. The Tribunal received oral evidence on behalf of the GMC from Patient A, who gave oral evidence in person on 30 March 2026. Her witness statement was dated 19 November 2025

10. Dr Davide provided his own witness statement dated 16 December 2025 and he also gave oral evidence at the hearing.

11. In addition, the Tribunal received evidence from the following witnesses on Dr Davide's behalf:

- Ms B, Nurse for Patient A's procedure. Her witness statement was dated 10 February 2026, and she gave oral evidence in person on 2 April 2026;
- Ms C, Patient Co-ordinator, sales manager, Director and owner at Top Cosmetic Surgery UK Ltd. Her witness statement was dated 5 February 2026, and she gave oral evidence in person on 2 April 2026;
- Dr D, Anaesthetist for Patient A's procedure. His witness statement was dated 6 February 2026, and he gave evidence in person on 2 April 2026.

Expert Witness Evidence

12. The Tribunal also received evidence from two expert witnesses.

- Dr E, Consultant Plastic Surgeon, was called on behalf of the GMC. Dr E provided an expert report dated 8 April 2025, and supplemental expert reports dated 21 July 2025 and 21 January 2026. She also gave oral evidence at the hearing.

- Dr F, Consultant Plastic Surgeon, was called on behalf of Dr Davide. Dr F provided an expert report dated 31 December 2025, and supplemental expert report dated 27 February 2026. He also gave oral evidence at the hearing.

- Dr E and Dr F also provided a joint expert report dated 12 March 2026.

13. The experts' evidence was provided to assist the Tribunal in understanding the professional standards to be expected of a Consultant Plastic Surgeon, and whether the level of care provided by Dr Davide to Patient A fell below those standards. In light of the Allegation, this was specifically in relation to Dr Davide's communication, record-keeping and consent-taking in respect of a bilateral blepharoplasty (upper and lower) and facelift given to Patient A.

Documentary Evidence

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

- Patient A's concerns form and summary, dated 13 September 2024;
- Patient A's Informed Consent form, dated 12 February 2022;
- Patient A's medical records, various dates;
- WhatsApp messages between Patient A and Ms C, and Patient A and Dr Davide, various dates 2021 to 2022;
- Civil litigation documents, various dates;
- Patient A face photographs (pre and post-surgery);
- Emails from Dr Davide's team to Patient A, various dates 2021 to 2022;
- Dr Davide's Rule 7 response dated 12 May 2025,

The Tribunal's Approach

15. The LQC gave legal advice to the Tribunal which can be summarised as follows:

16. The Tribunal was reminded that the GMC brings this Allegation and the burden of proving each paragraph is on the GMC. There is no burden on Dr Davide to prove anything.

17. The Tribunal was advised that it is the sole judge of fact, and to reach a decision, it must apply the civil standard of proof. This means that the Tribunal must decide whether, on the balance of probabilities, the GMC is able to prove that it is more likely than not that the fact occurred as alleged.

18. The Tribunal can bear in mind that Dr Davide is of good character. This means that he has no criminal convictions or cautions, or adverse misconduct related regulatory findings. The Tribunal is reminded therefore that the doctor might be:

(a) more likely to be telling the truth when giving his evidence, (ie credibility) and;

(b) less likely to have behaved in a way as set out in the Allegation (ie propensity)

19. However, good character does not amount to a defence, and its significance should not be over inflated. The primary focus should be on the evidence related to the wrongdoing.

20. The Tribunal should approach fact finding by firstly identifying the agreed facts and evidence.

21. The Tribunal should then consider what conclusions and inferences can be drawn from the documentary evidence. Inferences should be based on common sense conclusions based on the facts it has found. It should not speculate or make assumptions.

22. Having done so, the Tribunal should consider the available oral evidence and subject that evidence to critical scrutiny against the agreed facts and documentary evidence to consider a witness's reliability and credibility.

23. The case of *R (on the application of Dutta) v GMC* (2020) EWHC1974 (Admin) sets out the approach to be taken when assessing oral evidence. The Tribunal should not decide reliability and credibility based on the demeanour of a witness alone. A confident witness may give unreliable evidence. A nervous and hesitant witness may give reliable evidence. Memories can fade. However, the Tribunal is also reminded of the case of *Byrne v GMC*

[2021] EWHC 2237 (Admin), which, despite the concerns about demeanour set out in *Dutta,* at paragraph 8 of its judgment states:

> *'…Secondly, nevertheless, in assessing the reliability and credibility of witnesses, whilst there are different schools of thought, I consider that, if relevant, demeanour might in an appropriate case be a significant factor and the lower court is best placed to assess demeanour.'*

24. The case of *Byrne* stresses the necessity of careful analysis of all the evidence.

25. In summary, the Tribunal should have regard to the whole of the evidence and form its own judgement about the witnesses, and which evidence is credible and reliable, and which is not.

26. The Tribunal must judge Dr Davide's evidence by precisely the same fair standards as apply to any other evidence in the case. If the Tribunal accepts the evidence from a witness, rather than the evidence of Dr Davide it must explain why in its reasoning.

27. The Tribunal has heard from two experts in this case, who have given evidence that is outside the Tribunal's general knowledge. The Tribunal should consider whether the experts have sufficient expertise to express the opinions that they have on the topics that they have. This is a matter of weight for the Tribunal to assess. Conflicting expert views must be analysed on their coherence, consistency, and evidential foundation. Generally, a tribunal does not have to accept expert opinion, but if it decides not to accept it, or accepts one expert rather than another, then it must set out our reasons why that is the case.

The Tribunal's Analysis of the Evidence and Findings

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

29. In reaching its decision, the Tribunal first considered the conflicting accounts of Dr Davide and Patient A, and the reliability of their evidence. In essence, Patient A's account was that the matters set out within the Allegation were not discussed by Dr Davide, and the account of Dr Davide was that whilst he could not remember many of the specifics of his discussions with Patient A, it was his normal practice to cover those aspects set out in the Allegation.

30. The Tribunal accepted that Patient A may have been stressed when she attended the clinic for the Procedure, and indeed to give oral evidence at the Tribunal. It was aware that she was not in the best of health, and that she had referred this matter to the GMC because she felt that her face looked worse since the Procedure.

31. However, the Tribunal noted a number of inconsistencies in Patient A's accounts. She got the date of the first consultation mixed up and gave conflicting accounts as to whether there had been one or two preoperative consultations. Patient A said she arrived at the clinic at 10:30, which is not possible as the Procedure itself commenced at 10:32. She asserted that she received no pain relief, and no antibiotics, which was contradicted by the analgesia provided and the prescription handed to her by the nurse. She said she was not given a contact number, even though Dr Davide's mobile telephone number was on the Patient Discharge Summary given to her by the nurse. She said that Dr Davide was going to take her stitches out after the Procedure, when according to the WhatsApp records, she had been told that they would be taken out by a nurse. She gave her weight as 93 kgs, when her GP records confirmed that at that time, she was a stable 80kg.

32. The Tribunal concluded, therefore, it could not fully rely on Patient A's evidence. She was clearly deeply unhappy about the results of the Procedure, and it is possible that she had misremembered what happened on a stressful day. The Tribunal took the view that her memory may have faded and that her view of Dr Davide's actions might have been coloured by the passage of time.

33. The Tribunal also took into account the evidence given by Dr Davide. His evidence was unhelpful because he had little recollection of Patient A's case, and the conversations that he had with her. He had no notes, computer records, or mobile telephone data. He seemed to have no independent memory of the second consultation at all. In both his Rule 7 response and his witness statement he repeatedly referred to what would have been his 'standard practice,' but not the specifics relating to Patient A. His account was, therefore, generic and consistently vague.

34. In a similar vein, the Tribunal considered the evidence of Ms C. Again, the Tribunal could not fully rely on her evidence. She had little specific recollection of the conversations that had taken place with Patient A in the consultations, making the point that Dr Davide '*says the same things*' to each patient.

35. Given the conflicting accounts of Patient A and Dr Davide and the unreliability of their witness evidence, the Tribunal looked to the documentary and corroboratory evidence when

considering each paragraph of the Allegation and in deciding whose account it preferred in respect of each charge.

36. The Tribunal also noted that there was a conflict of evidence about the number of preoperative consultations that took place before the day of the Procedure. It saw firstly that it was not in dispute that there had been one consultation. There was, however, a conflict in evidence as to when it took place. For example, Patient A on her concerns form summary which she sent to the GMC, said that the preoperative consultation took place on 21 December 2021. In contrast, in her witness statement to the GMC she confirmed the date of 22 January 2022. In her oral evidence, Patient A was at first adamant that the consultation was on 22 December 2021 and said that it was *'before Christmas.'* She then accepted when she was re-examined by Mr Taylor, that 22 January 2022 was when she saw Dr Davide.

37. In both his Rule 7 response and his witness statement, Dr Davide stated that this consultation took place on 22 January 2022. In her evidence, Ms C stated that the consultation was on the 22 January 2022, and that she was present.

38. The Tribunal gave weight to the WhatsApp messages between Patient A and Ms C. On 22 January 2022, Ms C messaged Patient A that '*the video consultation'* is due to take place. At 9.48.04 hours, Patient A says, *'are we doing the call?'* and then at 10.19.56 hours, Patient A sends a message to Ms C which starts *'Hi [Ms C], what a lovely man…'*

39. The Tribunal concluded on the balance of probabilities that this consultation took place by video call on 22 January 2022 and lasted a maximum of 30 minutes.

40. The Tribunal then noted that, in both his Rule 7 response, and his witness statement, Dr Davide stated that there was a second consultation on 10 February 2022. Again, he did not produce any notes of this consultation. However, he produced a 'Patient Medical History' (PMH) form, which he said in evidence had been produced by Ms C from his notes of this meeting. The Tribunal saw an email that shows that someone from 'Top Cosmetic Surgeon' sent the PMH form to the surgical suite on 10 February 2022 in readiness for the Procedure on 12 February 2022.

41. Ms C in her evidence explained that there was a second consultation and that, again, she was present. She said that it must have been on the 10 February 2022, because that was when the emails were sent to both Patient A, and to the clinic from the 'Top Cosmetic Surgeon' email address. Ms C stated that the PMH form had been filled out at one of the consultations, probably by Dr Davide himself, and that once all the paperwork was ready it was sent to the clinic.

42. The Tribunal then considered the accounts given by Patient A. It noted that in the concerns form summary, she made no mention of a second consultation. However, it also noted that in Mr I's report, who was a Consultant Plastic Surgeon instructed to assist with the civil proceedings, it stated that Patient A told him that she recalled that *'she had two facetime consultations before undergoing her surgery. These took place sometime in January or early February 2022.*' Also, the Tribunal noted that the Particulars of Claim itself it states, '*the claimant had another remote consultation with the Defendant sometime prior to the index surgery and sometime in and around February 2022.'*

43. The Tribunal turned its attention to Patient A's witness statement and noted that in it she made no mention of a second consultation. In her oral evidence, she stated that she only had one remote preoperative consultation, that Mr I's report and the Particulars of Claim were incorrect, and that 22 January was *'the only time she set eyes on that man'* before the day of the surgery. When asked if her memory had faded, she said *'100% no.'*

44. Having weighed up the evidence, the Tribunal decided on the balance of probabilities that a second consultation was held on 10 February 2022. In summary, therefore it concluded that there were two consultations between Dr Davide and Patient A, one on 22 January 2022, and one on 10 February 2022.

45. The Tribunal also concluded that the PMH Form was filled out before the day of the Procedure. In her oral evidence, Patient A said that she filled the PMH form (or one very similar to it) by hand on the day of the Procedure. However, the Tribunal relied on the fact that it was typed not handwritten and sent by email on 10 February 2022 to the clinic. It also noted that the nurse at the clinic, Ms B, confirmed in her evidence that the PMH Form was Dr Davide's own form, and not one that she used when carrying out the pre-procedure checks. The form had Dr Davide's details at the top, and not the clinic's.

46. The stem of the Allegation was that Dr Davide performed a bilateral blepharoplasty (upper and lower) and a facelift ('the Procedure') on 12 February 2022. In broad terms, this was not disputed. The Tribunal noted however, that there was some discrepancy as to whether a full facelift or a mini facelift had been carried out. The original quote from Dr Davide was for a '*mini facelift',* and the Procedure Consent form which was filled out on the day of the Procedure by Dr Davide, states that a '*mini facelift,'* was to be carried out, which he confirmed in his evidence. A 'Particulars of Claim' document, produced as part of the subsequent civil proceedings, signed by Patient A as true on *'11/30/2023'*(sic), states that she had a 'short scar facelift.' In contrast, the Pre Operative form, the Patient Discharge

Summary, and both the nurse's and the anaesthetist's note from the day of the Procedure, all state '*facelift.*'

47. The Tribunal took the view that it was likely that a mini facelift had been carried out, and noted that the expert, Dr F, confirmed that this matched the time taken for the Procedure. In any event, it did not consider that the stem was affected by the type of facelift that Dr Davide had performed.

48. Also, the Tribunal considered the word 'failed' which formed part of the stem and took it to mean that it was alleging that Dr Davide did not do an action. It considered that any assessment of his performance in failing to do something was a matter for a later stage of these proceedings.

1(a)

49. The Tribunal considered whether, on the balance of probabilities, Dr Davide had performed the Procedure on Patient A and failed to obtain informed consent, as Patient A was not informed of the risk of delayed wound healing.

50. When considering this paragraph, the Tribunal accepted that taking consent from a patient does not require a written and signed consent form, and that it can be given verbally, with a discussion between the patient and the surgeon.

51. Considering Patient A's evidence, the Tribunal noted that she initially approached Top Cosmetic Surgery UK Ltd having searched on the internet for plastics surgeons. She said that on 22 January 2022 she spoke to Dr Davide for the first time through a remote video call on WhatsApp. She said that they discussed what surgery she was looking to have done. She said that Dr Davide told her she *'would be a good candidate for a face/neck lift and upper/lower blepharoplasty',* and that he would make her *'look beautiful'.* It was clear that Patient A was keen to be ready for her XXX on 26 March 2022, and she said that he assured her that she would heal by then. She said:

> *'In this appointment, I repeatedly asked Dr Davide about the healing time as I was concerned that I wouldn't heal in time for my [XXX] on 26 March 2022. Dr Davide and Ms C told me that I would heal from the surgery in 10 days.'*

52. Patient A went on to say that Dr Davide did not take any medical history from her during this consultation nor discuss *'any risks associated with the history.'* She maintained in her evidence that there was not a second consultation.

53. In contrast, Dr Davide in his statement said that during this consultation he advised Patient A that the time for her wound healing given her high BMI/body fat levels would be in the region of 10 days. He also said, *'I tell smokers that they must refrain from smoking prior to and for a period after the surgery for both safety reasons and also not to cause delayed wound healing and infection.*' Dr Davide then explained that he could not independently remember the second consultation but said that he had filled out the PMH form on that occasion and asked the numerous questions that are on it.

54. The Tribunal took into account the WhatsApp messages between Patient A and Ms C. They show that Patient A was concerned about her face having healed by her XXX, and Ms C reassured her by saying '*he said 10 days.'* In her evidence, Ms C said that 10 days was the normal time for healing, which contradicts Dr Davide's assertion that the number of days had been tailored to Patient A's personal condition.

55. The Tribunal looked to see what other documentation there was to assist in making this decision. It noted that there were no consultant notes from the two preoperative consultations, but it seemed to be accepted by both Patient A and Dr Davide that Dr Davide informed Patient A that 10 days would be the expected healing time for her.

56. The Tribunal considered the medical records from the day of the Procedure. It took into account the Informed Consent form and noted that Patient A had signed the first page out of a six-page document. It saw that Dr Davide had stamped all six pages. Patient A said that she was handed this form by the nurse, and that she was not given time to read it. The Tribunal thought that due to the lack of initialling or signing, and her explanation, it was likely that Patient A had not read the unsigned pages of this form.

57. On page two of that Informed Consent form, there is a section entitled '*delayed wound healing'* which states that '*wound disruption or delayed wound healing is possible. Some areas of the face may not heal normally and may take a long time to heal. Areas of skin may die. This may require frequent dressing changes or further surgery to remove the non-healed tissue. Smokers have a greater risk of skin loss and wound healing complications.'* Dr Davide stamped this page on the day of the Procedure.

58. The Tribunal then noted that there was a further form entitled 'Procedure Consent Form.' This was for the surgeon to fill out and did not necessitate a patient's signature. Dr

Davide has signed and stamped this form on the day of the Procedure. It states as follows (with Dr Davide's handwritten comments in bold):

> *'I confirm that I have explained the treatment (s) to the patient as named on this document. In particular, I have explained the following:*
>
> > *The intended benefits – **improvement***
> >
> > *Any serious or frequently occurring risks from the treatment, including those specific to the patient **-haematoma and necrosis***
> >
> > *…*
>
> *I have discussed what the treatment is likely to involve, the benefits and risks of any available alternative treatments (including no treatment), and any particular concerns that the patient has.'*

59. The Tribunal was told that haematoma meant bruising and necrosis referred to tissue death. The Tribunal reminded itself that the Informed Consent form under the heading 'Delayed Healing' noted one contributory factor was that areas of skin may die, hence it took that haematoma and necrosis as risks would also cause delayed healing. The Tribunal took the view that Dr Davide had very little recollection of events. However, it relied on the Procedure Consent Form, which he signed and stamped on the day of the Procedure. It sets out that Dr Davide informed Patient A of the risks from the treatment. When read in conjunction with the Informed Consent form that he also stamped, the Tribunal regarded it as evidence that Dr Davide had informed Patient A of the risk of delayed wound healing.

60. Given the inconsistencies and unreliability of the accounts of Patient A and Dr Davide, the Tribunal attributed greater weight to that contemporaneous documentary evidence.

61. The Tribunal considered that the evidence did not provide a detailed picture of the consent process, but did indicate that the risk of delayed wound healing was discussed with Patient A.

62. Accordingly, the Tribunal found paragraph 1(a) of the Allegation not proved.

1(b)(i)

63. The Tribunal considered whether, on the balance of probabilities, Dr Davide had performed the Procedure on Patient A and failed to communicate to her that her body mass index ('BMI') was too high.

64. In her witness statement, Patient A said that, during the remote consultation *'…there was no discussion about my weight or my psychological wellbeing. At the time of the surgery, I weighed 93 kilograms…'*

65. In his witness statement, Dr Davide said *'I asked [Patient A] what her height and weight was and from this I calculated her BMI. I advised her that she would need to loose weight to have general anaesthesia and she made it clear that she would find it difficult to loose weight [sic] … I discussed with [Patient A] the option of having a bilateral blepharoplasty (upper and lower) and facelift under local anaesthesia and sedation.'*

66. From the WhatsApp messages, however, the Tribunal noted that Patient A informed Ms C that she had some results from a CT scan and that she had *'emphysema and something to do with thyroid.'* The Tribunal understood that it was on that basis that the anaesthetist decided that Patient A should not have a general anaesthetic but should be given local anaesthetic and light sedation.

67. Later in his statement, Dr Davide confirmed that he did not recall the discussion that took place during the second consultation. The PMH form does, however, show that Patient A's weight and height was mentioned, from which a BMI could easily be calculated.

68. However, Dr Davide goes onto explain that:

> *"…I would not have discussed [Patient A's] weight/body fat levels since I do not consider that these are relevant to bilateral blepharoplasty (upper and lower) and facelift surgery. The reason for this is that even where someone has high BMI the amount of extra fat on the face is not such that it will significantly affect a mini-facelift and bilateral blepharoplasty surgery or the outcome of the surgery and the risk of infection for such facial surgery is very low."*

69. Dr Davide reiterated this position during his oral evidence. However, in Ms E's expert report, she gave the opinion that '*Dr Davide could have suggested a weight loss before surgery was conducted for a better healing of the tissues.'*

70. The Tribunal noted there were no records to assist it in making its deliberations. It was clear that Patient A was obese at the time of the Procedure, because a number of notes confirm this, namely the PMH form itself, and the notes from the GP, the nurse and the anaesthetist.

71. The Tribunal therefore considered the evidence of Patient A and Dr Davide. Patient A said her weight was not discussed. The Tribunal took the view that Dr Davide's evidence was inconsistent. The assertion that he informed Patient A that she must lose weight in order to have general anaesthesia is not borne out by the WhatsApp messages, and later in his statement he said that he would not have discussed her BMI for the purposes of the Procedure.

72. Given the lack of documentary evidence that this matter was discussed, and in light of Dr Davide's position on the subject, the Tribunal determined that this had not been communicated to Patient A.

73. Accordingly, the Tribunal found paragraph 1(b)(i) of the Allegation proved.

1(b)(ii)

74. The Tribunal considered whether, on the balance of probabilities, Dr Davide had performed the Procedure on Patient A and failed to communicate to her that she should stop smoking three weeks before the procedure.

75. The Tribunal noted that there was conflicting information about the optimum period of time that a patient should be informed to stop smoking in the lead up to a procedure of this nature. Some of the records suggest a six-week period, and when asked in oral evidence, Ms E and Mr F both stated that a period of two-four weeks could suffice. Ms E explained that there were no medical guidelines that mandate a specific timeframe.

76. In her witness statement, Patient A said that during the preoperative consultation, Dr Davide did not take her medical history but just assured her that she would '*look beautiful*' for her XXX.

77. In his witness statement, Dr Davide explained that he recorded on the PMH form that Patient A was a smoker and that she had been smoking 10 a day for XXX years. He then said that it was his '*standard practice to inform the patient at both remote consultations that they must refrain from smoking before the surgery and until I advise it is safe to resume smoking.*'

78. As part of the PMH form, the Tribunal noted a section for a patient to sign which states:

> *'I understand that I must refrain from smoking for at least six weeks before the surgery and until my surgeon states that it is safe to return to smoking. I acknowledge that I will inform my surgeon if I continue to smoke within this time frame and understand that for my safety the surgery may be cancelled.'*

79. The Tribunal noted that Patient A had not signed this form. Even if it had been filled out on 10 February 2022 and Dr Davide had advised her to not to smoke at this consultation, then the time framework of three weeks would have already passed.

80. The Tribunal considered the other medical records from the day of the Procedure. It was clear from both the nurse and anaesthetist notes that Patient A was still smoking. In none of those records does it show that Patient A had been advised to stop smoking by Dr Davide. This is contrary to Dr Davide's assertion in his Rule 7 response, dated 12 May 2025, which stated *'Prior to completing the consent form, I understood that [Patient A] had followed the earlier advise [sic] and refrained from smoking prior to the surgery and therefore the need to advise her that smoking would cause delayed wound healing was not needed.'* It was not clear to the Tribunal the basis on which Dr Davide reached this conclusion as there was no supporting documentary or witness evidence to do so.

81. The Tribunal read the Informed Consent form and noted that there is a specific section on smoking. It states that patients who are smokers are at a *'greater risk for significant surgical complications of skin dying, delayed healing, and additional scarring.'* The patient is asked to confirm whether if they are a non-smoker, or if a smoker, that they understand the risks involved. The section in this case is left blank which means that Patient A did not confirm in writing whether she was a smoker or not. Neither did she initial nor sign the document on that page.

82. The Tribunal concluded that Dr Davide was aware that Patient A was a smoker because of the detail that he entered on the PMH form. There is no documentary evidence to demonstrate that he asked her to stop. This is in contrast to the GP records that set out each time that Patient A was recorded to be smoking the GP documented advice to stop smoking. Dr Davide himself cannot recollect informing Patient A to stop smoking and relied on his standard practice when making his statement. The Tribunal concluded therefore that Dr Davide did not communicate to Patient A that she stop smoking.

83. Accordingly, the Tribunal found paragraph 1(b)(ii) of the Allegation proved.

1(b)(iii)

84. The Tribunal considered whether, on the balance of probabilities, Dr Davide had, performed the Procedure on Patient A and failed to communicate to her that there was an increased risk of infection.

85. In his witness statement, Dr Davide again stated that he had no recollection of the consultation of 10 February 2022, but he noted that on the PMH form there is a question of '*Are you allergic to anything?,'* and that he recorded Patient A as answering '*No.'* Dr Davide explained that it was his standard practice to discuss the risk of infection with the patient, taking into account their particular characteristics and specific medical history, at the same time as discussing allergies. He explained that was because he would need to consider prescribing antibiotics to reduce the risk of infection and some people are allergic to certain antibiotics.

86. The Tribunal considered the oral evidence of the nurse, Ms B. She said that she heard Dr Davide starting to take consent from Patient A. She said that they were in the preassessment room and then moved out of hearing into another room. She said that she heard Dr Davide discuss timings, and the risk of bleeding. She said he mentioned the need for a bandage and explained the drains. Ms B confirmed that she also discussed the possibility of infection with her, along with an explanation about how to manage drains when Patient A was in the hotel overnight.

87. The Tribunal noted from the Informed Consent form that there is a section relating to infection which reads:

> *'Infection infection is unusual after surgery. Should an infection occur, additional treatment including antibiotics, hospitalization, or additional surgery may be necessary.'*

88. The Tribunal saw that Patient A had signed the page just below this section, and Dr Davide stamped it too.

89. The Tribunal then considered other medical records from the day of the Procedure. It saw on the Patient Discharge Summary that the nurse had noted that she explained the signs of infection to look out for.

90. The Tribunal noted also that Dr Davide did prescribe antibiotics, as this can be seen from the prescription given to Patient A by the nurse after the Procedure. The Tribunal understood from the expert Mr F that giving antibiotics is not standard but is tailored to the patient.

91. In summary, the Tribunal considered that there was contemporaneous evidence that the increased risk of infection was communicated to Patient A and that she was prescribed antibiotics to address this risk, although the extent of such discussions was not clear.

92. Accordingly, the Tribunal found paragraph 1(b)(iii) of the Allegation not proved.

1(b)(iv)

93. The Tribunal considered whether, on the balance of probabilities, Dr Davide had performed the Procedure on Patient A and failed to communicate to Patient A about her lung condition.

94. Again, the Tribunal took into account the witness statement of Patient A who said that her medical history was not discussed with Dr Davide.

95. The Tribunal also considered Dr Davide's witness statement. He referred again to the PMH form and stated; '*The form records amongst other things that [Patient A] was being investigated for lung disease, being tested for sleep apnoea and waiting on investigations for COPD.'*

96. The Tribunal read the PMH form and saw that it had a number of questions that had been filled out. Those relevant to this paragraph are:

'have you been told by a doctor that you have a lung disease?'
'are you waiting on any investigations?'
'have you ever had any breathing problems'
'does breathing affect your lifestyle'
'Do you have sleep apnoea'
Do you smoke – if so how long have you smoked and how many per day'

97. The Tribunal took the view that all the questions above were related to the condition of Patient A's lungs.

98. The Tribunal also noted again, from the WhatsApp messages, that the anaesthetist was made aware of the emphysema diagnosis on 8 February 2022, which resulted in him taking the decision to give a local anaesthetic and sedation rather than general anaesthetic.

99. Relying on the PMH form, the Tribunal decided on the balance of probabilities, that Dr Davide did have a conversation with Patient A about her lung condition. He had answered the questions posed on her behalf and had noted that she was being investigated for lung disease, being tested for sleep apnoea and waiting on investigations for COPD.

100. Accordingly, the Tribunal found paragraph 1(b)(iii) of the Allegation not proved.

1(d)(i)

101. The Tribunal considered whether, on the balance of probabilities, Dr Davide had performed the Procedure on Patient A and failed to adequately record the reasons for the proposed Procedure.

102. The Tribunal firstly took into account the joint report of Ms E and Mr F, the two experts in this case. It is dated 12 March 2026. In it, they agreed that Dr Davide had not adequately recorded the matters set out in paragraphs d(i), (ii) and (iii). They said that his *'documentation of those matters are largely absent and therefore both agree with statements d(i-iii).'* The Tribunal noted that Dr Davide did not dispute their opinion.

103. The Tribunal understood that Patient A had requested the procedure, and that it was cosmetic rather than necessary. It read the quote that Patient A had been sent for the Procedure. It confirmed the type of procedure and the price as:

> *'Face mini lift (Jowls) £4500*
> *£1200 Upper lids*
> *£1200 Lower Lids'*

104. The Tribunal then noted that Dr Davide had filled out two forms on the day of the Procedure and signed and stamped them on that day. On the Procedure Consent Form, Dr Davide described the procedure as '*mini facelift, and blepharoplasty'* with *'improvement'* marked as the intended benefit. On a 'Surgeon Consent Form' he did not fill out why the Procedure was being carried out, despite it having a section on there where he could have circled one or more options.

105. The Tribunal took into account Dr Davide's explanation that he gave in his evidence. He explained that his notes for this case had been lost - in that they had been misplaced in his home.

106. The Tribunal noted that there was some documentation that set out the proposed Procedure but accepted the expert's view on this paragraph and decided on the balance of probabilities that Dr Davide did not adequately record the reasons for the proposed procedure.

107. Accordingly, the Tribunal found paragraph 1(d)(i) of the Allegation proved.

1(d)(ii)

108. The Tribunal considered whether, on the balance of probabilities, Dr Davide had performed the Procedure on Patient A and failed to adequately record the possible needs of pre-operative discussions and investigations.

109. In doing so it reminded itself of the joint view of the expert witnesses that those matters are largely absent and Dr Davide had not adequately discussed them.

110. The Tribunal received no documentary evidence to support that these matters had been discussed, and the only positive evidence was that of Dr Davide who stated that he discusses such matters as part of his standard practice.

111. Dr Davide had stated that he had made notes at the time but had been unable to locate these. Therefore the Tribunal was unable to determine what those notes may contain and as such it did not attach weight to Dr Davide's account of their existence.

112. Accordingly, the Tribunal found paragraph 1(d)(ii) of the Allegation proved.

1(d)(iii)

113. The Tribunal considered whether, on the balance of probabilities, Dr Davide had performed the Procedure on Patient A and failed to adequately record a treatment plan.

114. The Tribunal noted that as part of the PMH form, Dr Davide had written that a *'mini facelift, lower bleph, upper bleth'* in a section entitled *'surgeons notes.'* It also reminded itself of the quote that was sent to Patient A.

115. Firstly, the Tribunal again reminded itself of the opinion of the experts relating to Dr Davide's documentation, and his own explanation that his notes had been misplaced.

116. When considering the evidence of the experts, it took into account the oral evidence of Ms E, who had been called by the GMC. She was asked about the description that Dr Davide had given on the PMH form. She explained that it was not on the correct form and was under the wrong title of '*Patient Medical History',* and on that basis she felt that it was not an adequate record. She said that her view on its adequacy would depend on '*who is going to read it.'* When asked for more detail, Ms E said she would expect more detail- for example, how the Procedure was going to take place (ie under what type of anaesthetic), whether it was a day case or if the patient was to stay in hospital, any preoperative investigations there had been, what the actual procedure was going to be, the tools needed for the surgery, and details of after care for the patient. Ms E summarised her evidence on this point by stating that because it was under the wrong heading, it was not an adequate treatment plan, and that if it were under a correct heading it would be a *'minimal'* treatment plan.

117. The Tribunal considered this evidence carefully. It noted that there were no records to show that Patient A was given a treatment plan. Also, it took the view that a very brief plan comprising of one sentence set out in the wrong area of the notes would not be adequate for other practitioners to understand what the plan was for this Procedure. Further, the details, when considered together, represented the bare minimum expected of a treatment plan and did not constitute an adequate record.

118. Accordingly, the Tribunal found paragraph 1(d)(iii) of the Allegation proved.

<u>1(e)(i)</u>

119. The Tribunal considered whether, on the balance of probabilities, Dr Davide had performed the Procedure on Patient A and failed to record, in the alternative, his actions as outlined in paragraph 1(a).

120. The Tribunal considered this paragraph because it had found paragraph 1(a) not proved. However, when considering paragraph 1(a) it relied on the record that Dr Davide made on the day of the Procedure, namely the Procedure Consent Form, where he had both signed and stamped a declaration that confirmed that he had discussed *'any serious or frequently occurring risks from the treatment*'.

121. Having relied on this document, and the Informed Consent form both of which Dr Davide stamped on the day of the Procedure, the Tribunal concluded that there is insufficient evidence to demonstrate that Dr Davide had failed to record that he had informed Patient A of the risk of delayed wound healing in her case.

122. Accordingly, the Tribunal found paragraph 1(e)(i) of the Allegation not proved.

1(e)(ii)

123. The Tribunal considered whether, on the balance of probabilities, Dr Davide had performed the Procedure on Patient A and failed to record, in the alternative, his actions as outlined in paragraph 1(b)(i)-(iv).

124. Firstly, the Tribunal noted that, having found paragraph 1(b)(i) and 1(b)(ii) proved, then this paragraph need not be considered so far as those allegations are concerned.

125. The Tribunal therefore considered this paragraph in relation to paragraph 1(b)(iii) and 1(b)(iv), because these matters had been found not proved.

126. In relation to paragraph 1(b)(iii) the Tribunal concluded that there was no record of Dr Davide's communication with Patient A about the increased risk of infection in her case. The Tribunal had pieced together what was likely to have been communicated from aspects of the PMH form, the provision of non-standard antibiotics, and Ms B's notes and her evidence describing what she recalled being said to Patient A on the day of the Procedure. It noted that, again, Dr Davide had produced no notes of the consultations that he had with Patient A.

127. The Tribunal concluded, therefore, that Dr Davide had not recorded his actions in that he had not recorded the communications that he had with Patient A about the increased risk of infection.

128. In relation to paragraph 1(b)(iv), the Tribunal had come to the conclusion that paragraph 1(b)(iv) was not proved, because it had relied on the PMH form that it had concluded that Dr Davide had filled out (or Ms C on his behalf). That form demonstrates that Dr Davide had a conversation about the fact that Patient A was under investigations relating to lung disease and COPD and was being tested for sleep apnoea.

129. The Tribunal concluded, therefore, that there was insufficient evidence to show that Dr Davide had failed to record his actions- in relation to his communication with patient A about her lung condition.

130. The Tribunal therefore found paragraph e(ii) proved in relation to 1(b)(iii) and not proved in relation to 1(b)(i), (ii) and (iv).

The Tribunal's Overall Determination on the Facts

131. The Tribunal has determined the facts as follows:

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

1. On 12 February 2022, you performed a bilateral blepharoplasty (upper and lower) and a facelift ('the Procedure') on Patient A and you failed to:

    a. obtain informed consent as Patient A was not informed of the risk of delayed wound healing; Not proved

    b. communicate to Patient A:

        i. that her body mass index ('BMI') was too high; Determined and found proved

        ii. that she should stop smoking three weeks before the procedure; Determined and found proved

        iii. that there was an increased risk of infection; Not proved

        iv. about her lung condition; Not proved

    c. ~~provide Patent A with post-operative follow-up every two weeks for a minimum of six to 12 months~~; Deleted under Rule 17(6)

    d. adequately record:

        i. the reasons for the proposed Procedure; Determined and found proved

        ii. the possible needs of pre-operative discussions and investigations; Determined and found proved

iii. a treatment plan; **Determined and found proved**

e. record, in the alternative, your actions as outlined in paragraphs:

i. 1a; **Not proved**

ii. 1b i-iv; **Determined and found proved in relation to 1(b)(iii), Not proved in relation to 1(b)(i), (ii) and (iv)**

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 - 10/04/2026

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

The evidence

2. The Tribunal reviewed its findings of fact and in addition, the Tribunal received further evidence as follows.

- A further statement from Dr Davide, dated 11 February 2026.
- A statement from Dr Davide's Responsible Officer, dated 12 February 2026.

3. The Tribunal also received in support of Dr Davide a number of testimonials from work colleagues.

4. Following questions from the Tribunal, it also received a written response to those questions from Mr Whittock.

5. The Tribunal also received documentary evidence, which included but was not limited to:

- CPD (Continuous Professional Development) certificates:

- Decision making and consent in accordance with the GMC professional standards, 2 hours, dated 26 September 2025;
- Importance of documentation and record keeping in accordance with the GMC Good Medical Practice 2024, 4 hours, dated 15 September 2025;
- Complaint management, conflict management and customer service, 2 hours, dated 4 September 2025;

- A number of blank consent forms and templates used by Dr Davide in his current practice, undated.

Submissions

Submissions on behalf of the GMC

6. Mr Taylor informed the Tribunal that it should now use the '*Medical Practitioners Tribunal Hearings'* section of the '*Guidance for use in Doctor's hearing'* which came into effect on 24 November 2025 ('the Guidance'). He drew the Tribunal's attention to *Part B step 2* and also the *Guidance Introduction* which has a section on *clinical concerns.*

7. Mr Taylor advised the Tribunal that it must have, at the forefront of its mind, the overarching statutory objective as set out in s(1) of the Medical Act 1983 which relates to public protection. He reminded the Tribunal of its three limbs, which are namely to protect, promote, and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the profession, and to promote and maintain proper professional standards and conduct for members of the profession. He submitted that all three limbs were engaged in Dr Davide's case.

8. Mr Taylor went through the two stage process that the Tribunal should now consider, namely whether Dr Davide's actions amount to misconduct, and if so, whether his fitness to practise is impaired.

9. Mr Taylor then took the Tribunal through the caselaw which assist in defining misconduct. He said that the misconduct must amount to serious professional misconduct, and that it might be seen as *'deplorable'* by fellow practitioners, but that '*mere negligence'* is not enough. He said that misconduct can be wide ranging and that it is therefore a decision that has to be made by the Tribunal, using its skilled judgment, and taking into account the facts, circumstances and evidence in the case. He said that serious professional misconduct comes in two broad types- namely actions that are sufficiently serious in the doctor's

professional practice, or conduct that is '*morally culpable or of a disgraceful kind*'. He submitted that both types applied in Dr Davide's case.

10. Mr Taylor submitted that in terms of misconduct, Dr Davide's actions amounted to a limited number of clinical acts or omissions that taken together are serious. He submitted that Dr Davide's failures fell seriously below the standard expected of a reasonably competent Consultant Plastic Surgeon, as was the opinion of the GMC expert witness Dr E. He said that in relation to Dr Davide's deficient record keeping, both Ms E and Mr F were agreed that Dr Davide's actions again fell seriously below the standard expected of a reasonably competent Consultant Plastic Surgeon.

11. Mr Taylor submitted that the failure to tell Patient A to give up smoking was particularly serious because even on his own account, Dr Davide said that he would not have performed the procedure had he known that she was still smoking, and that this was a procedure that the patient should never have had. He submitted that the consequences for Patient A have been dire, not only in terms of the money she had paid for the Procedure but also, more importantly, in terms of the distress and misery that these events have caused her.

12. Mr Taylor submitted that that it would be unusual for a proven allegation about a clinical concern not to impact on patient safety and that all three limbs of the overarching objective were engaged in this case.

13. Mr Taylor submitted that the Guidance states that:

> *Allegations that usually fall at the lower end of the spectrum of seriousness and due to their nature are more likely to be easily remediable include, but are not limited to:*
>
> - *clinical failings, including where a doctor has acted without regard for patients' rights or feelings provided this is not a wilful disregard of their wishes*

14. Mr Taylor submitted that there was not a wilful disregard of patient wishes in this case and that the allegations fall at the lower end of the spectrum of seriousness.

15. Mr Taylor submitted that there were no contextual factors which were relevant in this case.

16. Mr Taylor submitted that other than the CPD courses undertaken, there was no further detail or evidence that Dr Davide had kept his knowledge and skills up to date. He

submitted that the testimonials provided on Dr Davide's behalf were matters which would be relevant for the sanctions stage of proceedings, as indicated by the Guidance.

17. Mr Taylor submitted that the nature and quality of insight was lacking, with no apology or remorse at all shown in this case, noting that Dr Davide stopped dealing with and blocked Patient A once she had taken legal advice. He submitted that the lack of insight increases the level of current and ongoing risk to public protection posed by Dr Davide.

18. Mr Taylor submitted that Dr Davide was entitled to deny the allegations but it is relevant to the degree to which he genuinely understands the concerns and accepts his professional shortcomings. He submitted that when giving evidence, Dr Davide made some '*wholly inappropriate and unprofessional remarks'*, commenting that it would '*take a magician'* to make Patient A look beautiful. He submitted that in relation to his patients smoking or giving up smoking Dr Davide commented *'they always lie'*.

19. Mr Taylor submitted that Dr Davide displayed '*a casual, cavalier and unprofessional attitude',* which suggests that he does not take the various clinical deficiencies that have been identified in his case as seriously as he would like the Tribunal to think. He submitted that the Tribunal could therefore not be satisfied about the genuineness of any insight, which in this case was limited.

20. In terms of remediation, Mr Taylor submitted that the allegations are remediable but had not been fully remediated. He submitted that the concerns of the Case Examiners set out in their comments at the Rule 8 stage of proceedings still apply, namely that:

- *while Dr Davide acknowledged that his record-keeping could have been more comprehensive, he has not provided any explanation about the total absence of any clinical record of his pre-operative consultations with Patient [A] (other than the consent form and procedure consent form which were completed on the day of surgery) or of his postoperative consultations with her*
- *while Dr Davide has taken some steps towards improving standardised written information to be provided to patients, he has not indicated that he understands the need to document the actual discussions with and advice given to individual patients during consultations based on their specific circumstances, particularly if those discussions form part of the informed consent process. Nor has he demonstrated any development of insight into the need to record a treatment plan and rationale.*

21. Mr Taylor submitted that the evidence of remediation was somewhat superficial and perfunctory and that a detailed explanation of meaningful remediation was lacking.

22. Mr Taylor submitted that the evidence of three courses undertaken by Dr Davide total eight hours of online CPD and that the course on complaint management and conflict management is unrelated to clinical deficiencies which have been identified and suggests that Dr Davide sees this episode as a matter of complaint or conflict management.

23. He submitted that the various blank pro formas provided by Dr Davide show nothing in terms of how Dr Davide has remediated his deficiencies and that there was no evidence of the actual impact of any remedial actions on the standards of Dr Davide's documentation of treatment planning and record keeping.

24. Mr Taylor submitted that the Tribunal could have little confidence that there has been complete remediation, and therefore that there is no risk of repetition, adding that a low risk of repetition is a risk of repetition nonetheless.

25. Mr Taylor submitted that Dr Davide's actions represent serious departures from the proper professional standards expected of registered medical practitioners, and breached multiple paragraphs of Good Medical Practice (2013) ('GMP'), namely paragraphs 15, 16, 19, 21 and 49 (as set out below).

26. Mr Taylor summarised by setting out the position taken by Dame Janet Smith in the *Fifth Shipman Report*, as adopted by the High Court in *CHRE v NMC & Grant (2011) EWHC 927 (Admin).* He said that Dame Smith sets out some features that are likely to be present when impairment is found, and submitted that three of those were relevant here, namely where a doctor has in the past or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm, bring the medical profession into disrepute and/or breach one of the fundamental tenets of the medical profession. He ended then by saying that Dr Davide is impaired due to his misconduct.

Submissions on behalf of Dr Davide

27. Mr Whittock submitted that the matters before the Tribunal were in relation to communication and record keeping which occurred in February 2022, more than four years ago, and that the Tribunal was considering current impairment.

28. As Mr Taylor had set out the relevant sections of the Guidance, Mr Whittock stated that he did no need to go through them again for the Tribunal. He also agreed that the paragraphs quoted by Mr Taylor from GMP 2013 were engaged, as they related to record keeping and the sharing of information.

29. Mr Whittock submitted that in terms of misconduct, there is a limited number of clinical acts, and the Tribunal should consider whether, when taken together, they amount to a serious departure from the professional standards as set out in GMP. He submitted that the central difficulty in this case is the absence of documentation and that Dr Davide's evidence was that the notes he had taken of the two consultations had been misplaced.

30. Mr Whittock submitted that the allegations of failing to communicate the high BMI and to stop smoking three weeks before the procedure were not as serious as what had originally been alleged and the impact on risk of safety was also less significant considering that informed consent was obtained from Patient A.

31. Mr Whittock submitted that the allegation of communication of matters that affect risk were easily remediable by way of training on decision-making and consent and that the allegations concerning record keeping were also easily remediable by way of training.

32. Mr Whittock submitted that in terms of seriousness, the allegations fell at the lower end of the spectrum and that there was a lack of features which may increase the seriousness of the allegation. He submitted that whilst there were two remote consultations, these should not be viewed as being a persistent or repeated breach of the standards expected, and there was no relevant fitness to practise history.

33. Mr Whittock submitted that there was relevant context in that at the time that Dr Davide carried out the surgery, he was at a different clinic and he has since changed clinic. He submitted that at his current clinic Dr Davide has performed several hundred major surgical procedures with a very low rate of complications and without any problems with this documentation, as set out in the testimonial of the Director of the London Hair and Cosmetic Surgical Centre (LHCS) where he now practises.

34. Mr Whittock submitted that the statement of Dr Davide's Responsible Officer was objective evidence of insight, and that it has to be borne in mind that there is ongoing litigation between Patient A and Dr Davide which limits his ability to accept things and also offer an apology and admit he has done something wrong. He submitted that Dr Davide has engaged with the GMC investigation and fully cooperated with it.

35. Mr Whittock submitted that in terms of remediation, Dr Davide's witness statement sets out how he has refamiliarised himself with relevant GMC guidance and undertaken training on decision-making and consent, and documentation and record keeping. He

submitted that that is the very training that would be appropriate to remediate the allegations that have been found proved.

36. Mr Whittock submitted that in respect of the additional training, Dr Davide has undertaken for complaint management, conflict management and customer service, whilst this does not necessarily touch on the allegations that have been proved, it is clearly helpful in dealing with patients' concerns and should not be taken as a negative, but rather a positive.

37. He submitted that Dr Davide has adopted the use of a number of standardised consultation forms that are specific to the type of surgery that has been considered, and that on the basis of all the evidence, the matters have now been remedied.

38. Mr Whittock also asked the Tribunal to consider the testimonials provided on Dr Davide's behalf when reaching its determination on impairment. He submitted that these include evidence that Dr Davide has declined surgical intervention for patients who are medically unsuitable or for those whose expectations may be unrealistic.

39. Mr Whittock submitted that the allegation is highly unlikely to be repeated and that Dr Davide does not pose any current and ongoing risk to the three limbs of public protection requiring a finding of an impairment or restrictive action.

The relevant legal principles

40. The LQC gave the Tribunal legal advice, which is summarised below.

41. There is no burden or standard of proof at this stage of the proceedings and the decision of impairment is a matter for the Tribunal's judgment alone. The Tribunal will only make a finding of impairment where there is a legal basis for doing so and where a decision is reached that the doctor poses a current and ongoing risk to one or more of the three parts of public protection which is likely to require restrictive action in response. The three parts of public protection are to protect, promote and maintain the health, safety and well-being of the public; to promote and maintain public confidence in the profession; and to promote and maintain proper professional standards and conduct for members of the profession.

42. The Tribunal is advised to take into account Part B step 2 of the '*Medical Practitioners Tribunal Hearings'* section of the '*Guidance for use in Doctor's hearing'* which came into effect on 24 November 2025. It should also consider whether Dr Davide's actions fall within *Case Type 5* in the *General Introduction* of the Guidance which is entitled *'clinical concerns.'*

43. In approaching the decision, the Tribunal was reminded of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct, and that the misconduct was serious and then whether the finding of that misconduct which was serious poses a current and ongoing risk to public protection requiring restrictive action in response and therefore could lead to a finding of impairment.

44. 'Misconduct' has no statutory definition. It is a matter for the judgement and experience of the tribunal. However, in the case of *Roylance v GMC [No 2] [2000] 1 AC 311* it was said that 'misconduct' should be 'serious misconduct' before the Tribunal should move to consider fitness to practise. The word 'serious' should be given its ordinary meaning. This case stated that misconduct is '*some act or omission which falls short of what would be proper in the circumstances.'* The Tribunal should therefore take into account whether Dr Davide has departed from the standards set out in GMP 2013.

45. To assess whether Dr Davide poses any current and ongoing risk to public protection which may require restrictive action in response, the Tribunal will consider:

- where on the spectrum of seriousness the allegation lies, based on the facts found proved the impact of any relevant context known about Dr Davide and/or their working environment, and
- how Dr Davide has responded to the allegations.

46. The Tribunal should note that Dr Davide denied the Allegation. It is advised, however, that it should not necessarily equate the maintenance of innocence with a lack of insight. A tribunal should not punish a doctor for defending themselves, as they are entitled to do so, but it can weigh up what happened at the facts stage when assessing insight.

47. The LQC reminded the Tribunal that whilst there is no statutory definition of impairment, the Tribunal is assisted by the features set out in the case of *Grant* (ante). The Tribunal noted that any of the following features are likely to be present when a doctor's fitness to practise is found to be impaired:

a. *'Has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
b. *Has in the past and/or is liable in the future to bring the medical profession into disrepute; and/or*
c. *Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d. ….'

The Tribunal's determination on impairment

Is there a legal basis for considering impairment?

48. The Tribunal firstly had to decide whether there is a legal basis for considering impairment. It therefore considered whether the proven facts amounted to misconduct. The Tribunal was aware that the misconduct had to be serious professional misconduct before it could move to impairment.

49. The Tribunal noted that this case related to clinical concerns that took place as part of Dr Davide's professional working practice. It noted the table set out at paragraph 11 of the Guidance at section three. Under Misconduct it states that '*a limited number of clinical acts taken together'* can be serious.

50. The Tribunal decided that it should consider the proven paragraphs of the Allegation as a whole as they relate to Dr Davide's failure to communicate with one patient and adequately record the consultations that he had with her leading up to the Procedure.

51. The Tribunal reminded itself of the decisions it made at stage one of these proceedings. It had found that Dr Davide had failed to communicate with Patient A about her BMI before the Procedure on 12 February 2022, and he had not advised her to stop smoking three weeks before it. Also, Dr Davide had not adequately recorded the reasons for the procedure, the possible needs of preoperative discussions and investigations, and his communications with Patient A about the increased risk of infection in her case. Neither did he record a treatment plan. The Tribunal noted the impact that these failures had on Patient A. She had paid a sizeable amount for the surgery and was distressed by the result. It is possible, on Dr Davide's own account that the Procedure would not have taken place had he realised that she was still smoking up until the date of it. The Tribunal noted that the Procedure was voluntary and did not need to take place at that time, as it was for cosmetic purposes only. It accepted however, that there were no clinical concerns about the Procedure itself, nor its outcome.

52. The Tribunal firstly considered the evidence from the expert reports, and their view on the seriousness of Dr Davide's actions. Ms E stated that the following aspects of Dr Davide's performance fell seriously below the standard expected of a reasonably competent Consultant Plastic Surgeon:

1. *Note-keeping: The note keeping preoperatively with regards to possible needs of preoperative discussions and investigations was not sufficient, it falls seriously below the expected standards of care*

…

4 *Communication: It falls seriously below the expected standards of care not to have communicated with Patient [A]/her GP with regards to her increased BMI and lung condition prior to performing surgery for this patient.*

53. When explaining why she felt they fell seriously below the standard, Ms E stated:

'1. Note-keeping: The note keeping preoperatively with regards to possible needs of preoperative discussions and investigations was not sufficient, it falls seriously below the expected standards of care

…

4. Communication: It falls seriously below the expected standards of care not to have communicated with Patient [A]/her GP with regards to her increased BMI and lung condition prior to performing surgery for this patient'

54. Ms E's report also states:

'There was no discussion about Patient [A's] BMI being too high. There was also no advice for the patient to stop smoking and the failure to communicate the risk of infection and association with smoking of reduced circulation, which secondarily leads to infection.'

…the pre-operative discussions and note-keeping, and reasoning for the suggested surgery, was not properly outlined. There was not a treatment plan.'

55. The Tribunal noted that Mr F agreed with Ms E so far as in the inadequate recordkeeping is concerned.

56. From the expert evidence, therefore, the Tribunal concluded that Dr Davide's actions fell seriously below the standard expected of a reasonably competent Consultant Plastic Surgeon.

57. In respect of Dr Davide's failure to communicate to Patient A that her BMI was too high and that she should stop smoking three weeks before the procedure, the Tribunal considered that paragraphs 15, 16 and 49 of GMP were applicable, namely:

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

> *a adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
>
> *b promptly provide or arrange suitable advice, investigations or treatment where necessary*
> *…*

16 In providing clinical care you must:

> *a prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs*
>
> *b provide effective treatments based on the best available evidence*
>
> *…*

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

> *a their condition, its likely progression and the options for treatment, including associated risks and uncertainties*
>
> *…*
>
> *c who is responsible for each aspect of patient care, and how information is shared within teams and among those who will be providing their care*
>
> *…*

58. In respect of Dr Davide's failure to make adequate records, the Tribunal considered that paragraphs 19 and 21 of GMP were applicable, namely that:

19 Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.

21 Clinical records should include:

a relevant clinical findings

b the decisions made and actions agreed, and who is making the decisions and agreeing the actions

c the information given to patients

d any drugs prescribed or other investigation or treatment

e who is making the record and when.

59. The Tribunal therefore concluded that Dr Davide's actions had fallen far below the standards expected of him, and that he had departed from the professional standards set out in GMP in a number of respects. It decided therefore that fellow practitioners would be concerned about these actions and this standard of performance.

60. The Tribunal decided, therefore, that Dr Davide's failure to communicate with Patient A, and his lack of record keeping leading up to and during the day of the Procedure amounted to serious professional misconduct. It concluded therefore that there was a legal basis for it to consider impairment.

61. The Tribunal therefore went on to consider whether, as a result of that misconduct, Dr Davide's fitness to practise is currently impaired.

Where on the spectrum of seriousness does the allegation lie?

62. The Tribunal considered where on the spectrum of seriousness the allegation lies. In doing so, it reminded itself that its primary consideration was the risk posed to patients and the public arising from a departure from the professional standards.

63. In considering the seriousness of the allegations, the Tribunal noted that in relation to clinical concerns, the Guidance states:

164. Clinical concerns can include a wide range of matters relating to a doctor's behaviour and/or performance at work. A view will need to be reached about where on the spectrum of seriousness the concern or allegation lies with reference to the nature and extent of the departure from the professional standards and considering the presence of any features that increase seriousness. An expert opinion may be available to assist with this depending on the stage of the fitness to practise process the matter has reached.

64. The Tribunal was also assisted by paragraph 28 of the Guidance. It sets out the type of allegations that may fall at the lower end of the spectrum of seriousness, which, due to their nature, are more likely to be easily remediable. It lists examples, one of which is;

'clinical failings, including where a doctor has acted without regard for patient's rights or feelings provided this is not a wilful disregard of their wishes.'

65. The Tribunal agreed with the submissions made that Dr Davide had not shown a *'wilful disregard'* in this case. It also decided that the nature of Dr Davide's actions was easily remediable. It therefore took the initial view that his actions would fall at the lower end of the spectrum.

66. The Tribunal then considered whether there were any features about the allegation which may increase the seriousness. It took into account the table set out at paragraph 36 of the Guidance.

67. In the table, the Tribunal noted that allegations of poor performance that are '*persistent or repeated'* is listed as a potential feature. The Tribunal therefore considered Dr Davide's actions. It noted that they were repeated, as there were a number of matters that he had not recorded, and two clinical issues that he had failed to communicate to Patient A. However, it took the view that this Allegation related to one overall incident regarding one Procedure and one patient. It had not taken place over a prolonged period of time, nor had it affected others. It decided, therefore, that Dr Davide's actions were not *'persistent' or 'repeated'.*

68. Also in the table, the Tribunal noted that the Guidance sets out the following feature which may increase seriousness:

'An attempt to hide and/or avoid taking responsibility for behaviour or poor performance

A doctor must be open and honest if things go wrong. Where, at the time of the circumstances giving rise to the allegation, they attempt to hide unacceptable behaviour or poor performance or avoid taking responsibility for their behaviour or poor performance by blaming others for their own acts or omissions, this can have a negative impact on patient safety and/or workplace culture. This type of behaviour can only arise in a doctor's working life.'

69. The Tribunal noted that Dr Davide did not have much independent recollection of events and was vague in his replies when he gave his oral evidence. He said that patients '*lie*' when asked about their smoking habits. Also, Dr Davide relied on others to prepare his defence for him. His Rule 7 response for example, was signed by him even though the author of it had spelt his name wrong. The Tribunal concluded therefore that there was some evidence that Dr Davide was not taking these allegations seriously, was avoiding taking responsibility, and demonstrated a tendency to shift blame to his patients. In so far as Patient A was concerned, although he had communicated with her after the Procedure, he blocked her after she had taken legal advice.

70. The Tribunal determined that this feature slightly increased where on the spectrum of seriousness the allegation fell. It decided that the starting point for assessing the risk to public protection was at the higher end of low. It concluded that Dr Davide's actions could be mitigated and addressed.

71. The Tribunal was of the view that the risk that Dr Davide poses relate to all three aspects of public protection, which are to protect, promote and maintain the health, safety and well-being of the public, promote and maintain public confidence in the profession, and promote and maintain proper professional standards and conduct for members of the profession.

<u>What is the impact of any relevant context known about Dr Davide and/or their working environment?</u>

72. The Tribunal then moved on to consider whether there were any relevant matters that it should take into account arising from Dr Davide's working context, his role and experience, or personal circumstances.

73. The Tribunal noted that Dr Davide had been working in private practice and had all the necessary support and facilities that he might have needed. The systems and processes that were in place protected him, and he had assistance in setting up appointments and arranging facilities, with Ms C acting as patient coordinator and chaperone. The Tribunal

concluded that there was nothing about the working environment that it could identify that could affect Dr Davide's performance.

74. The Tribunal did not accept the submission made by Mr Whittock on Dr Davide's behalf that there was relevant context in relation to his working environment as the time Dr Davide treated Patient A, he was at a different clinic and had since changed clinic.

75. The Tribunal noted that Dr Davide is an experienced consultant who has practised in cosmetic surgery for a number of years. He is highly qualified in this field. It read that he had moved from Italy to practise in the UK in 2018, some four years before the Procedure. He appeared personally busy, but that was of his own making and for him to manage. The Tribunal concluded that there was nothing about Dr Davide's role, experience, or personal circumstances that it could identify that could affect Dr Davide's performance.

76. Accordingly, the Tribunal determined that there were no applicable contextual factors which would alter the level of seriousness or starting point for assessment of public protection, which remained at the high end of low.

How has Dr Davide responded to the allegations?

77. The Tribunal then considered carefully the way in which Dr Davide has responded to these allegations. It considered insight, remediation, and the risk of repetition.

78. The Tribunal firstly looked to see if there was evidence of insight, and whether that insight was genuine.

79. The Tribunal firstly noted that Dr Davide had cooperated with the GMC and its investigation. He denied the Allegation at stage one of the proceedings, which he is entitled to do. It understood that Dr Davide's denial of the allegations should not be held against him but also considered the Guidance, which states:

> *89. A doctor has the right to advance a robust defence to an allegation. This includes requiring the GMC to prove their case and bring witnesses to hearings. As a result, an apology may not be forthcoming until after a witness has engaged in the hearing. In other cases, if the defence put forward by the doctor is not successful, it may be unrealistic to expect them to immediately accept every finding, in a fully sincere manner, or apologise.*

90. However, in these circumstances it may still be possible for the doctor to provide some evidence of insight without them having fully admitted the circumstances of the allegation. Where a doctor gives evidence at a hearing, the MPT will be able to test evidence of insight through oral testimony to assess whether it is genuine.

80. The Tribunal therefore considered the evidence that Dr Davide gave at stage one of the proceedings. Dr Davide did not demonstrate that he understood the seriousness of the allegations, nor the impact on Patient A. For example, when Dr Davide was asked whether he told Patient A that he would make her '*look beautiful'* he replied to the affect that he was '*not a magician.'* Also, when he was asked if he advised Patient A to stop smoking, he said that patients *'lie'* anyway.

81. The Tribunal took this evidence into account when assessing Dr Davide's level of insight. It bore in mind the Guidance, which states:

93. In some circumstances, it may be reasonable to conclude that a doctor lacks genuine, or any, insight. This may be because there is evidence they have:

…

- *tried to minimise the seriousness or impact of their behaviour, poor performance or health condition*
- *provided an explanation after the event in which they have tried to minimise their own role or culpability, or otherwise sought to blame others*

82. The Tribunal then considered Dr Davide's witness statement dated 11 February 2026. It is short and relates only to the steps he has taken to remediate his actions. He does not address insight nor reflect on his performance at all. The Tribunal noted especially that there was no apology to Patient A, nor expression of remorse of empathy. He did not acknowledge the impact to her, to public confidence or standards for the profession. On his behalf, Mr Whittock explained that this was because of the ongoing civil litigation, but that explanation did not assist the Tribunal in assessing insight.

83. The Tribunal concluded that the only evidence of insight could be found in the statement dated 12 February 2026 from Dr Davide's Responsible Officer. He sets out the courses that Dr Davide has undertaken, and when doing so he said:

'Dr. Davide outlined that he:

• Viewed the process as very valuable, notwithstanding being emotionally challenging, as it resulted in a more positive, structured, and reflective approach

• Acknowledges that his documentation would have benefitted from being more comprehensive

• Reflected deeply on the patient's dissatisfaction

• Is committed to patients feeling respected, supported, and empowered to express concerns

• Strives to ensure that patients have positive experiences, and that he incorporates patient feedback into how he approaches his work.'

84. The Tribunal therefore accepted from the Responsible Officer that Dr Davide has reflected to some extent, by accepting that his documentation should have been more comprehensive and understanding the effect of his actions on patients.

85. The Tribunal concluded that there was very limited evidence of insight in Dr Davide's case and that it was at best in its infancy.

86. The Tribunal next looked to see if there was evidence of remediation. Due to the clinical nature of this case, the Tribunal formed the view that Dr Davide's actions were clearly remediable, so it then moved on to consider what steps he had taken to remediate.

87. The Tribunal again considered Dr Davide's witness statement dated 11 February 2026. He said that he had re-familiarised himself with GMC materials namely GMP 2024, 'Decision Making and Consent 2020', and 'Cosmetic Interventions 2016.'

88. Dr Davide also confirmed that he undertaken some courses in September 2025. He said:

'I undertook interactive training … for:
a. Decision Making and Consent
b. Documentation and Record Keeping
c. Complaint Management, Conflict Management and Customer Service.'

89. The Tribunal noted that Dr Davide produced the certificates for these courses and had informed his Responsible Officer of them. The Tribunal saw that all the courses took place in

September 2025. They were online and totalled eight hours of CPD. The Tribunal thought that the courses listed at *a* and *b* above were relevant to the allegations he was facing.

90. The Tribunal accepted from the Responsible Officer that Dr Davide had '*Viewed the process as very valuable, notwithstanding being emotionally challenging, as it resulted in a more positive, structured, and reflective approach.'*

91. The Tribunal was of the view, however, that the courses Dr Davide had undertaken were limited, and that there was little evidence of his reflections on them, what he had learned, and what he would do differently in future.

92. The Tribunal then carefully considered Dr Davide's change in circumstances. He said in his statement that since 2022 he has worked at LHCSC and that there are a number of standardised processes and forms in place relating to consultations which allows him to record both history and risk. Dr Davide listed and enclosed a number of those forms. He also explained that he now records his post-operative care notes on a patient management programme used by the clinic either directly or by writing them on paper and requesting his secretary to input them.

93. The testimonial from Dr G, a consultant from LHCSC, stated that Dr Davide *'is up to date with mandatory training and appraisal, and we don't have any problems with his documentation at the clinic.'* The Tribunal accepted that this demonstrated that there appear to be no present concerns about Dr Davide's documentation, but it did not show what personal efforts he has made to change and improve his performance.

94. Also, the Tribunal noted that Dr Davide was presently working in places other than LHCSC and was planning to do so in the future. He would personally need therefore to ensure that he communicates with patients at the appropriate times and adequately records preoperative consultations.

95. The Tribunal took the view that a change of hospital in 2022, with its different procedures and processes, did not demonstrate that Dr Davide had taken ownership of his actions, or personal responsibility to remediate going forward.

96. The Tribunal concluded that overall, there was some evidence of remediation but that it was limited, and that Dr Davide had not demonstrated that he had meaningfully linked this to his insight or applied it to his practice.

97. The Tribunal noted from the Responsible Officer that Dr Davide confirmed that he is committed to maintaining a high standard of clinical practice and ensuring that his delivery of safe and effective care is performed in accordance with professional and regulatory requirements.

98. Despite this assertion, the Tribunal concluded that it had received very limited evidence of both insight and remediation. It then noted paragraph 114 of the Guidance which asks the Tribunal to consider the question '*is the allegation highly unlikely to be repeated?*' It noted that there had been no repetition since the events, but owing to the limited insight and remediation, it concluded that a risk of repetition necessarily remained.

99. The Tribunal decided, therefore, that its initial view that Dr Davide's current and ongoing risk to public protection is low, should be increased to medium.

Tribunal's decision as to whether Dr Davide poses any current and ongoing risk to public protection which may require restrictive action in response and its finding on impairment

100. The Tribunal next had to consider, overall, whether, on the basis of the conclusions it had reached, Dr Davide poses any current and ongoing risk to public protection which may require restrictive action on his registration, and its decision on impairment.

101. The Tribunal had concluded that Dr Davide's actions fell at the lower end of the spectrum of seriousness, and therefore that its start point had been that Dr Davide poses a low risk to public protection. The Tribunal found no contextual factors for it to change that view.

102. The Tribunal had therefore determined that the starting point for assessing the risk to public protection was low. However, when later considering insight and remediation, the Tribunal reassessed the risk that Dr Davide poses to public protection as medium.

103. In relation to patient safety, the Tribunal determined that Dr Davide's conduct had resulted in distress to Patient A. It bore in mind the Guidance, which states:…

> *A doctor's clinical failings may impact on the physical, emotional and/or psychological wellbeing of a patient or member of the public. The impact of clinical failings can be long lasting and may affect how a patient accesses health services in the future. Where a clinical failing has, or could have, impacted on patient care, there is a clear risk to patient or public safety.*

171. Where an allegation about a clinical concern leads to a finding of impairment, it may engage one or more of the three parts of public protection. Whilst the MPT must consider the individual circumstances of the case, it will be unusual for a proven allegation about a clinical concern not to impact on patient safety.

104. Accordingly, the Tribunal determined that a finding of impairment was necessary in order to uphold the first limb of public protection, namely, to protect, promote and maintain the health, safety and well-being of the public.

105. In relation to public confidence, the Tribunal determined that a fully informed member of the public would be seriously concerned by Dr Davide's conduct, and ongoing lack of insight. Accordingly, it determined that a finding of impairment was necessary in order to uphold the second limb of public protection, namely, to promote and maintain public confidence in the medical profession

106. In relation to professional standards, the Tribunal determined that a finding of impairment was also necessary to uphold the third limb of public protection, namely to maintain proper professional standards and conduct for members of that profession.

107. Accordingly, the Tribunal determined that a finding of impairment was necessary in order to uphold all three limbs of public protection.

108. In applying the test set out in *CHRE V Nursing and Midwifery Council and Grant 2011 EWHC 927 (Admin)* the Tribunal was satisfied that the first three limbs of the test for impairment were engaged, in that Dr Davide:

a. 'Has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
b. Has in the past and/or is liable in the future to bring the medical profession into disrepute; and/or
c. Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession;

109. The Tribunal therefore determined that Dr Davide's fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 14/04/2026

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

2. At the outset of the sanction stage, Mr Taylor explained that Mr Whittock had presented the GMC with a draft Schedule of Undertakings for it consider. However, Undertakings were not then agreed, and therefore the Tribunal was asked to consider sanction in the normal way.

The Evidence

3. The Tribunal received a further defence bundle at this stage. It included:

- A further statement from Dr Davide;
- Examples of medical records that Dr Davide had filled out during recent procedures at the hospitals where he was working;
- Certificates of courses that Dr Davide has attended;
- Information about further courses that Dr Davide has enrolled on.

4. Dr Davide also gave oral evidence at this sanction stage.

Submissions

Submissions on behalf of the GMC

5. On behalf of the GMC, Mr Taylor reminded the Tribunal that the decision on sanction is a matter for the Tribunal using its own judgment, and that the overarching objective of public protection should be at the forefront of its mind. He said that at the impairment stage, the Tribunal concluded that all three limbs of public protection were engaged, and he submitted that they still apply now.

6. He referred the Tribunal to the Guidance at *Section three - Part C*, which relates to sanctions, and pointed out that the Tribunal has four options, namely, to take no action, impose conditions, suspension, or erasure.

7. Mr Taylor took the Tribunal through its Determination at the impairment stage and referred to specific paragraphs for it to now consider. He reminded the Tribunal that it had

found that Dr Davide had demonstrated very limited evidence of insight, which was at best in its infancy, and that there was some evidence of remediation, but that it too was limited. It had also concluded that the courses that Dr Davide had undertaken were limited, and that simply moving hospitals did not demonstrate the personal efforts he had made to remediate.

8. Mr Taylor said that the new material that had been received, and the evidence that Dr Davide gave, should not change those observations. He submitted that the material had all been '*done at the eleventh hour,'* because the seriousness of the Tribunal's decision had *'dawned on'* Dr Davide. He said that the Procedure on Patient A had taken place in February 2022, and yet the new forms that had been received relate to very recent operations (2025 and 2026) and were dissimilar in type. He said that Dr Davide was now booked on some further courses, but that they were only booked on or around Sunday 12 April 2026. He queried therefore whether his efforts were genuine, or an attempt to placate the Tribunal. He said that the provision of new forms from a different hospital did not change the fact that Dr Davide had limited remediation. In fact, Mr Taylor pointed out that in Dr Davide's new statement he was seeking to blame the London Surgical Suite for the loss of his notes.

9. Mr Taylor drew the Tribunal's attention to the views of the case examiner in their Rule 8 comments. They had concluded that Dr Davide's recordkeeping could have been more comprehensive, and that he had not provided an explanation for the absence of documentation. They also felt that Dr Davide had not demonstrated that he understood the importance of recording the actual discussions with a patient. Mr Taylor said that those concerns still apply.

10. Mr Taylor referred to Dr Davide's new witness statement. He said that Dr Davide apologised for the unprofessional comments he made to the Tribunal when he gave his oral evidence, explaining that he was under stress at the time. Mr Taylor suggested that Dr Davide did not appear to be under stress when giving this evidence. He said that there was also an absence of regret and remorse in relation to Patient A's case. Mr Taylor also pointed out that Dr Davide had said at the impairment stage that he was working solely at the LHCSC, and yet it was now clear that he was working at two other hospitals. Mr Taylor said that Dr Davide's explanation in his oral evidence at this stage - that his own patients were at LHCSC and that he operated on other patients at the other hospitals - was unconvincing. He said that Dr Davide should have been apologising to the Tribunal for having been misleading. He pointed out that Dr Davide had said nothing about the impact of his actions on either public confidence or the proper professional standards of the medical profession.

11. Mr Taylor said that, therefore, all three limbs of public protection still apply in this case, and that the risk level of medium still remains.

12. Mr Taylor then moved on to what the appropriate sanction might be in this case. He referred to the case of *Bolton v Law Society* [1994] 1 WLR 512, which states that mitigation in regulatory cases has less effect than in criminal cases because of the need to maintain a well-founded confidence in the profession. He said that the reputation of the profession is more important than the needs and fortunes of any of its individual members.

13. Mr Taylor then took the Tribunal through the Guidance at *section three -part C.* He said firstly that there were no exceptional circumstances in Dr Davide's case, and that taking no action should not therefore be considered.

14. Mr Taylor then moved onto the section in the Guidance that relates to the imposition of conditions. He pointed out that, at paragraph 23, the Guidance states that conditions are likely to be workable where a doctor has shown insight and submitted that the problem for Dr Davide is that there is a lack of evidence of genuine insight. He also pointed to paragraph 28, which states that conditions might be a proportionate sanction if a doctor has demonstrated that they are willing to be *'open and honest with patients and other they work with if things go wrong.'* He suggested that this was also linked to insight, along with Dr Davide's reaction and attitude to the case generally.

15. Mr Taylor then asked the Tribunal to consider suspension. He said that suspension would be an appropriate and proportionate response in this case, and commensurate with the Tribunal's previous findings that Dr Davide poses a medium risk to public protection. He took the Tribunal to paragraph 45 of the Guidance, which sets some of the factors that might be present where suspension might be a proportionate sanction. He said, for example, that conditions are not appropriate, and that suspension is necessary to stop Dr Davide from working and putting patients at risk while he gains insight into his performance.

16. Mr Taylor then asked the Tribunal to consider the length of the proposed suspension. He said that up to 12 months can be imposed, and that a review should be directed toward the end of the period. In relation to sanction bandings, Mr Taylor then referred to the table in the Guidance set out in paragraph 62. He reminded the Tribunal that for clinical concerns, with a medium level of risk to public protection, it should be considering an imposition of conditions for between 24-36 moths, or a suspension for a period of up to six months.

17. Mr Taylor said that the testimonials can be considered at this stage, but that the Tribunal should consider paragraphs 71 and 72 of the Guidance and therefore that the need to protect the public should outweigh any relevant evidence about the doctor's character.

18. Mr Taylor stated that he did not wish to address the Tribunal in relation to erasure, as the GMC did not think that Dr Davide's actions were fundamentally incompatible with registration in the future, and that it would be disproportionate in any event. He confirmed that he was submitting that a period of suspension would be the appropriate sanction in Dr Davide's case.

Submissions on behalf of Dr Davide

19. Mr Whittock confirmed firstly that Dr Davide has now accepted, on reflection, that there were areas on which he could improve, and therefore he agreed that '*taking no action*' was not an option.

20. Mr Whittock stated that the two sanctions that should be considered were the imposition of conditions, or a period of suspension. He reminded the Tribunal of the sanctions bandings, and that this case related to clinical concerns, with an assessment at the impairment stage of Dr Davide's registration being a medium risk to public protection. He pointed out that the bands were a guide and a range and that relevant evidence could still be taken into account. He submitted that Dr Davide's case was at the lower end of the band.

21. Referring to the Guidance, Mr Whittock said that, in his view, conditions were appropriate, measurable and workable, and that the risk to public protection can be safely mitigated by their imposition. He said both a period of suspension and erasure would be disproportionate. He said that Dr Davide's actions are easily remedied and that he had identified some further training that he had already booked to attend. He said that the impact on Dr Davide were he to be suspended would be devastating for him, and that it would also affect his colleagues. He said that he had been practising for 37 years, the Procedure was four years ago, and that the likelihood of repetition is low.

22. Mr Whittock drew the Tribunal's attention to Dr Davide's new witness statement prepared and produced at this sanction stage, as well as the new material. He said that Dr Davide has tried to explain that the London Surgical Suites could have lost some notes, because there were some missing pages in the medical records that had been retrieved from them for the Tribunal hearing.

23. Mr Whittock took the Tribunal through the new forms that Dr Davide was now using and the examples he had provided from each of the three hospitals that he was now working at. He pointed out that there was an appropriate time period between consultations and procedures, and that issues of smoking and BMI were addressed.

24. Mr Whittock went through the new courses that Dr Davide was now signed up to. They were three in total. He said that the *Professional Behaviours in Aesthetic surgery (PBAS) virtual course o2E* was a significant course with pre course work and attracted 15 CPD hours. He said that the other two courses, on *Consent and Ethics,* and *Preoperative Care* attracted 16 credits in total.

25. Mr Whittock confirmed that Dr Davide had kept his skills and knowledge up to date and that his appraisal was coming up in June 2026, for which he was going to provide a reflections document. He also pointed to the testimonial evidence. He said that Dr G, the principal consultant and surgeon at LHCSC, confirms that Dr Davide had performed hundreds of operations at the centre and was presently conducting two or three a week. Mr Whittock pointed out that Dr G had no concerns about Dr Davide's documentation. He also referenced the testimonials from Mr J and Dr K.

26. Turning back to the possibility of conditions, Mr Whittock said that Dr Davide's new statement demonstrated that he was willing to comply with supervision, and that he was able to remedy his actions. He said that Dr Davide's attitude was not a problem, and that his actions were not at the higher end of the spectrum of seriousness.

27. Mr Whittock said that a number of conditions would be suitable in Dr Davide's case. He referred to the Conditions Bank and took the Tribunal through the conditions he felt appropriate and that Dr Davide could and would comply with. In answer to a suggestion from Mr Taylor that was put to Dr Davide that the procedure should not have been carried out if Patient A was still smoking, Mr Whittock took the Tribunal to the joint expert report. He quoted from the report which states:

> *'Both experts would not have operated upon her for various reasons e.g. BMI, respiratory issues and smoking. However, they both acknowledge that there are practitioners who would still have operated on her. However, this would not represent best practice and may result in post-operative issues.'*

28. Mr Whittock confirmed that whilst not best practice, it was not wrong to operate. He said that risks had been mitigated in Patient A's case. Dr Davide was a very experienced surgeon, and Patient A was given a local anaesthetic and sedation rather than a general anaesthetic. She was also prescribed antibiotics to reduce the risk of infection.

29. Mr Whittock concluded by stating that conditions could be imposed in Dr Davide's case.

The Tribunal's Determination on Sanction

30. The Tribunal had regard to the statutory overarching objective in Section 1 of the Medical Act 1983 throughout its deliberations. It considered the submissions made by both counsel and was reminded by the LQC that the procedure to be adopted was under the Guidance at *section three – Part C* and of the case of *Bolton v Law Society* (ante). It bore in mind that any sanction must be proportionate, transparent and fair and that purpose of a sanction is not to be punitive, but to protect patients and the wider public interest.

31. The Tribunal firstly reminded itself of its findings at both the facts and impairment stages.

32. At the facts stage, the Tribunal found that Dr Davide had failed to communicate with Patient A about her BMI, and he had not advised her to stop smoking three weeks before the Procedure. Also, Dr Davide had not kept adequate records in a number of respects. The Tribunal noted the impact that these failures had on Patient A. She had paid a sizeable amount for the surgery and was distressed by the result. However, it accepted the joint expert report that while not best practice, it was not wrong to have operated on Patient A, and that there are practitioners who would have done so. It also accepted that there were no clinical concerns about the Procedure itself, nor its outcome.

33. At the impairment stage, the Tribunal had assessed the seriousness of the allegations as low but concluded that he represented a medium level of risk to public protection based on his very limited insight and remediation.

34. The Tribunal considered the Guidance and looked at the table which sets out the sanctions bandings for certain case types. It noted that, Dr Davide's case fell within *clinical concerns*, and due to its findings, it was within *medium level of risk to public protection.* The Tribunal concluded therefore that, in the ordinary course of events, it should be considering *conditions 24-36 months to suspension 6 months.*

35. The Tribunal was aware that the sanctions bandings were a helpful guide and range, but that, as described at paragraph 66 of the Guidance, additional evidence can be taken into account that might be relevant to sanction and what is appropriate. To that end, the Tribunal considered the new material that it had received.

36. It firstly considered the new witness statement of Dr Davide. In it, Dr Davide apologised for his unprofessional comments when he gave oral evidence at the facts stage of the proceedings, explaining that it is a very stressful time for him. He said that he has now

improved both his communication with patients and record keeping, and on reflection and in light of the findings of the Tribunal in this matter he accepts that this an area which could be improved upon. The Tribunal accepted therefore that Dr Davide was beginning to recognise his mistakes and is prepared to remediate. However, while it noted his apology, he still did not apologise to Patient A or express empathy or remorse.

37. The Tribunal then went onto consider the new material that Dr Davide produced alongside his statement. It accepted that he had enrolled on three relevant courses, albeit late in the day. It noted the other courses that he had attended which he did not mention at the impairment stage but provided certificates for. It saw the new forms that Dr Davide was using at each of the three hospitals that he was working at and saw that they referred to BMI and advice about smoking. It noted that these were recent forms that had been filled out by Dr Davide, rather than blank ones which had been produced at the impairment stage.

38. From this new material, the Tribunal accepted that Dr Davide had demonstrated improved record keeping and a readiness, again, to remediate. There were early signs that Dr Davide would address his shortcomings. However, the Tribunal agreed with the GMC contention that this new material had been produced very late, and in response to the Tribunal's Determination. This affected the weight that could be given to it.

39. The Tribunal also took into account the oral evidence that Dr Davide gave at this stage of the hearing. He summarised by saying that he regretted that it had happened, and that this process in itself had been a *'very good lesson'* for him for the future. He said that he was committed to changing his behaviour and to training in the future.

40. While the Tribunal accepted that Dr Davide has now begun a journey of insight and remediation, it concluded that he still poses a medium risk to public protection because the new material and his reflections came only during the weekend after the Tribunal had handed down its Determination on impairment.

41. However, the Tribunal decided that the new material did place Dr Davide at the lower end of the medium risk banding. It bore this in mind when considering the proportionate sanction in Dr Davide's case.

42. In conjunction with this new material, the Tribunal took into account the fact that Dr Davide is keeping his skills and knowledge up to date and has good testimonials from his present hospitals. Dr G, for example, confirmed that Dr Davide had operated on hundreds of patients at LHCSC and was presently doing 2-3 days per week, with no concerns about his

record keeping. The evidenced from the testimonials again mitigates the risk that Dr Davide poses to public protection.

43. The Tribunal then considered the Guidance and considered the least restrictive action first.

No action

44. The Tribunal considered that there are no exceptional circumstances in this case which would warrant the taking of no action in the context of the facts found proved and the Tribunal's determination on impairment. It considered that taking no action would not be sufficient, proportionate, or in the public interest.

Conditions

45. The Tribunal next considered whether to impose conditions on Dr Davide's registration. It noted the relevant paragraphs of the Guidance and bore in mind that any conditions imposed would need to be appropriate, workable, measurable and proportionate.

46. The Tribunal firstly noted that at paragraph 23 of the Guidance it states that conditions are likely to be workable where:

> *a. the doctor has shown insight*
> *b. time is needed for the doctor to take steps to address the findings (remediate), for example through retraining, study, supervision and/or seeking medical treatment*
> *c. the doctor is willing to remediate, and*
> *d. the MPT is satisfied the doctor will comply with them.*

47. The Tribunal noted that Dr Davide had demonstrated some, albeit limited insight. It accepted that Dr Davide is now willing to remediate and had no reason to think that he would not comply with any conditions that were put in place. The Tribunal had only very recently received an acknowledgment from Dr Davide that remediation was needed, and he has now provided some evidence of the steps he is taking to improve his performance.

48. The Tribunal concluded therefore that conditions would be workable in Dr Davide's case. Also, as it had decided that Dr Davide fell at the lower end of the medium range of risk to public protection, it considered that conditions would be an appropriate sanction in this case.

49. The Tribunal then went onto consider whether any conditions imposed on Dr Davide would be measurable. It was aware that Dr Davide's shortcomings related to a discrete area of his practice, and not to his surgical skills. They related to communicating with patients and record keeping. As such, the Tribunal took the view that a review hearing would be able to measure Dr Davide's remediation, improvement and insight in this regard.

50. The Tribunal then went on to consider whether imposing conditions on Dr Davide was a proportionate response. It noted at paragraph 28 it sets out that conditions may be proportionate in cases where the doctor has shown a degree of insight into the allegation and some or all of the following factors are present;

a. *the doctor has demonstrated they are willing and/or able to remediate*
b. *identifiable areas of the doctor's practice need prohibiting, monitoring, or retraining*
c. *the doctor has demonstrated they are willing to be open and honest with patients and others they work with if things go wrong*
d. *the doctor will not put patients at harm, either directly or indirectly, by having conditions on their registration.*

51. The Tribunal took the view that Dr Davide has shown '*a degree of insight*'. It decided also that Dr Davide is able to remediate his actions and has demonstrated that he is now willing to do so. It noted that Dr Davide has organised some courses to assist with retraining and improving going forwards and did not consider that conditions on his practice would result in harm to patients. It concluded therefore that the imposition of conditions is a proportionate response in this case.

52. In summary, the Tribunal concluded that a period of conditional registration would be the appropriate sanction in the case of Dr Davide.

53. Further, the Tribunal in considering the impact of its decision on public confidence in the medical profession, was satisfied that a fully informed member of the public would regard the imposition of workable conditions as proportionate and appropriate.

54. Overall, the Tribunal determined that it was satisfied that conditions would be workable, measurable and proportionate to address the three limbs of public protection.

Suspension

55. The Tribunal did not make a final decision in relation to sanction, however, until it had considered the possibility of suspension. It was aware that suspension is intended to address the level of current and ongoing risk to public protection and is not intended to be punitive. It also noted that suspension can also have a deterrent effect and be used to send a signal to the doctor, the profession and the public about what is regarded as behaviour unbefitting a registered doctor.

56. The Tribunal noted from paragraph 45 of the Guidance:

> *45. Suspension may be proportionate in cases where some, or all, of the following factors are present:*
>
> *a. conditions are not appropriate, measurable and/or workable*
> *b. the level of current and ongoing risk to public protection is such that it cannot be safely managed with conditions and suspension is necessary to stop the doctor from working and putting patients at risk while they gain insight into any deficiencies and remediate, or undergo medical treatment, and/or*
> *c. the level of current and ongoing risk to public protection is such that, although patient safety is not an issue, suspension is needed to maintain public confidence in the profession and/or maintain professional standards.'*

57. The Tribunal concluded that conditions were appropriate, measurable, and workable in Dr Davide's case, as set out above. It felt that the level of risk that Dr Davide poses is quite discrete as it relates to communications and record keeping and is easily remediable. It concluded that suspension is not necessary to maintain public confidence or to maintain professional standards within the profession.

58. Moreover, the Tribunal had earlier made the decision that Dr Davide poses a medium risk to public protection, but that this risk fell within the lower end of the range. Suspension was at the higher end of this range, so it concluded that it was not necessary to suspend Dr Davide in order to mitigate the risk to public protection.

59. The Tribunal was also aware that Dr Davide has been practising for a period of 37 years, and over the past four years, since the Procedure, there have been no further incidents relating to his treatment of patients.

60. In these circumstances, the Tribunal concluded that the imposition of conditions represented a proportionate response to address the three limbs of public protection. The Tribunal further determined that a sanction of suspension would be disproportionate and unduly punitive.

Erasure

61. The Tribunal did not consider erasure and nor was erasure advanced, as it was not sought by the GMC.

Length of conditions

62. In considering the length of the order, the Tribunal again had regard to the sanctions banding. It noted that the suggested sanction for a medium level of risk in a case regarding clinical concerns was conditions for 24-36 months to up to 6 months of suspension. The Tribunal had regard to paragraph 63 of the Guidance, which states:

> *'In all cases, once the MPT has identified the level of banding, they will need to decide the appropriate length of sanction to impose within that range, provided they are satisfied it is the most proportionate type of action considering the individual circumstances of the case. The following factors will be relevant to deciding the appropriate length of time that conditions or suspension should be put in place for:*
>
> *…*
>
> *the amount of time the doctor is likely to need to remediate, complete treatment for and/or recover from a health condition that is having, or is likely to have, an impact on their ability to practise safely and effectively.'*

63. The Tribunal determined that the appropriate length of any conditions should be 24 months. This was at the lower end of the range for medium risk case relating to clinical concerns. It considered that this period would allow Dr Davide sufficient time to address the concerns surrounding his practice.

64. The Tribunal concluded that this was the least restrictive sanction it should impose for the protection of the patients and the public and to uphold confidence in the medical profession and to maintain professional standards.

65. The following conditions, all taken from 'the conditions bank', will be published:

> 1 Dr Davide must personally ensure the GMC is notified of the following information within seven calendar days of the date these conditions become effective:

a the details of his current post, including:
i his job title
ii his job location
iii his responsible officer (or their nominated deputy)
b the contact details of his employer and any contracting body, including his direct line manager
c any organisation where he has practising privileges and/or admitting rights
d any training programmes he is in

2 He must personally ensure the GMC is notified:
a of any post he accepts, before starting it
b that all relevant people have been notified of his conditions, in accordance with condition 5
c if any formal disciplinary proceedings against him are started by his employer and/or contracting body, within seven calendar days of being formally notified of such proceedings
d if any of his posts, practising privileges or admitting rights have been suspended or terminated by his employer before the agreed date within seven calendar days of being notified of the termination
e if he applies for a post outside the UK

3 He must allow the GMC to exchange information with any person involved in monitoring his compliance with his conditions.

4 a He must have a workplace reporter appointed by his responsible officer (or their nominated deputy).
b He must not work until:
i his responsible officer (or their nominated deputy) has appointed his workplace reporter
ii he has personally ensured that the GMC has been notified of the name and contact details of his workplace reporter.

5 He must personally ensure the following persons are notified of the conditions listed at 1 to 8:
a his responsible officer (or their nominated deputy)
b the responsible officer of the following organisations:
i his place(s) of work, and any prospective place of work (at the time of application)

ii all his contracting bodies and any prospective contracting body (prior to entering a contract)

iii any organisation where he has, or has applied for, practising privileges and/or admitting rights (at the time of application)

iv any locum agency or out of hours service he is registered with.

v If any of the organisations listed at (i to iv) does not have a responsible officer, he must notify the person with responsibility for overall clinical governance within that organisation. If he is unable to identify this person, he must contact the GMC for advice before working for that organisation.

6 a He must design a personal development plan (PDP), with specific aims to address the deficiencies in the following areas of his practice.

- Communicating with patients, especially in relation to Informed consent
- Record keeping, especially in relation to consultations with patients.

b His PDP must be approved by his responsible officer (or their nominated deputy)

c He must give the GMC a copy of his approved PDP within three months of these substantive conditions becoming effective.

d He must give the GMC a copy of his approved PDP on request.

e He must meet with his responsible officer (or their nominated deputy), as required, to discuss his achievements against the aims of his PDP.

7 He must contact the GMC within seven calendar days of returning to the UK.

8 a He must be supervised in all of his posts by a clinical supervisor, as defined in the *Glossary for undertakings and conditions*. His clinical supervisor must be approved by his responsible officer (or their nominated deputy).

b He must not work until:

i his responsible officer (or their nominated deputy) has appointed his clinical supervisor and approved his supervision arrangements

ii he has personally ensured that the GMC has been notified of the name and contact details of his clinical supervisor and his supervision arrangements.

Review

66. The Tribunal had regard to paragraph 38 of the MPTS Guidance which states:

> *'38. The question of whether the doctor can safely return to unrestricted practice will need to be considered before a period of conditions concludes and so a review should be directed.'*

67. The Tribunal determined that, because Dr Davide is still at the early stage of insight and remediation, it was appropriate to direct a review of his case. A review hearing will convene shortly before the end of the period of conditional registration.

68. The Tribunal wishes to clarify that, at the review hearing, the onus will be on Dr Davide to demonstrate how he has remediated, developed insight and kept his skills and knowledge up to date. It may however assist the reviewing Tribunal if Dr Davide provides:

- Evidence of developed insight, for example, producing a reflective statement;
- Evidence he has kept his clinical skills and knowledge up to date;
- Any relevant CPD or proof of remediation;
- Evidence of how he has applied his learning to his day-to-day practice to help reduce the risk of reoccurrence;
- Anything else Dr Davide thinks may assist the reviewing Tribunal.

Determination on Immediate Order - 14/04/2026

1. Having determined to impose conditions on Dr Davide's registration, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order.

2. Due to another engagement, Mr Taylor could not attend the hearing today. Mr Ged Doran, Counsel, replaced him on behalf of the GMC at this stage in proceedings.

Submissions

3. On behalf of the GMC, Mr Doran submitted that the GMC adopts a neutral position in respect of an immediate order, and that the decision whether to impose such an order is a matter for the Tribunal's discretion, having regard to the facts of the case.

4. On behalf of Dr Davide, Mr Whittock drew the Tribunal's attention to the Guidance. He said that the decision was a matter for the Tribunal's discretion and submitted that there is no need for an immediate order in this case. He referred to paragraphs 74 and 79 in particular, and pointed out the immediate orders only need to be imposed where it is necessary to protect the public or is otherwise in the public interest.

5. Mr Whittock reminded the Tribunal that it has already determined that Dr Davide's actions were at the lower end of the spectrum of seriousness and that the risk he poses to public protection was medium. He said that immediate action was not necessary because Dr Davide was not posing a high risk. He reminded the Tribunal that Dr Davide had been practising for 37 years and had been working in the four years since the Procedure with no restriction. He also said that his shortcomings were in a discrete area relating to communication and recordkeeping.

6. Mr Whittock concluded that when considering all the circumstances of this case, the matters are only related to a discrete area of Dr Davide's practice, and an immediate order is not necessary.

The Tribunal's Determination

7. The Tribunal accepted that it may impose an immediate order if it considers it necessary for the protection of members of the public or is otherwise in the public interest.

8. The Tribunal had regard to paragraphs 83 and 84 of the Guidance, which sets out.

> *'83. The decision whether to impose an immediate order is at the discretion of the MPT based on the facts of the case. When deciding if an immediate order is needed the MPT should consider the seriousness of the proved allegation and the level of current and ongoing risk to public protection posed by the doctor.*
>
> *84 It will not usually be appropriate for a doctor to hold unrestricted registration until a sanction takes effect in cases where:*
>
> *a. the doctor poses a risk to patient safety*
> *b. the risk to one or more parts of public protection is high, and/or*
> *c. immediate action is needed to maintain public confidence in the medical profession.'*

9. In its deliberations, the Tribunal reminded itself that it had identified clincial concerns relating to patient communciations and recordkeeping. Allthough these are discrete areas of

work, at the earlier stages of these proceedings, it had concluded that Dr Davide's actions were at the lower end of the spectrum of seriousness but nevertheless created a medium risk to public protection because of his limited insight and remediation. It had concluded that all three limbs of public protection were engaged.

10. The Tribunal took the view that, although there was not a high risk to any of the limbs of public protection, there was nevertheless a risk to patient safety. It took the view that there was a still a risk of repetition because of Dr Davide's limited insight and remediation. This was the reason that conditions had been imposed at the sanction stage.

11. The Tribunal also felt that public confidence could be affected if conditions were not immediately imposed allowing a doctor to continue practising unrestricted. The Tribunal was satisfied therefore that an immediate order was also required to maintain public confidence and professional standards in the medical profession

12. The Tribunal considered that the requirement of an immediate order was consistent with its decision on impairment and sanction.

13. The Tribunal therefore determined to impose an immediate order of conditions.

14. The following conditions, all taken from "the conditions bank", will be published:

1 Dr Davide must personally ensure the GMC is notified of the following information within seven calendar days of the date these conditions become effective:

- a the details of his current post, including:
  - i his job title
  - ii his job location
  - iii his responsible officer (or their nominated deputy)
- b the contact details of his employer and any contracting body, including his direct line manager
- c any organisation where he has practising privileges and/or admitting rights
- d any training programmes he is in

2 He must personally ensure the GMC is notified:

- a of any post he accepts, before starting it
- b that all relevant people have been notified of his conditions, in accordance with condition 5

c if any formal disciplinary proceedings against him are started by his employer and/or contracting body, within seven calendar days of being formally notified of such proceedings

d if any of his posts, practising privileges or admitting rights have been suspended or terminated by his employer before the agreed date within seven calendar days of being notified of the termination

e if he applies for a post outside the UK

3 He must allow the GMC to exchange information with any person involved in monitoring his compliance with his conditions.

4 a He must have a workplace reporter appointed by his responsible officer (or their nominated deputy).

b He must not work until:

i his responsible officer (or their nominated deputy) has appointed his workplace reporter

ii he has personally ensured that the GMC has been notified of the name and contact details of his workplace reporter.

5 He must personally ensure the following persons are notified of the conditions listed at 1 to 8:

a his responsible officer (or their nominated deputy)

b the responsible officer of the following organisations:

i his place(s) of work, and any prospective place of work (at the time of application)

ii all his contracting bodies and any prospective contracting body (prior to entering a contract)

iii any organisation where he has, or has applied for, practising privileges and/or admitting rights (at the time of application)

iv any locum agency or out of hours service he is registered with.

v If any of the organisations listed at (i to iv) does not have a responsible officer, he must notify the person with responsibility for overall clinical governance within that organisation. If he is unable to identify this person, he must contact the GMC for advice before working for that organisation.

6 a He must design a personal development plan (PDP), with specific aims to address the deficiencies in the following areas of his practice.

- Communicating with patients, especially in relation to Informed consent
- Record keeping, especially in relation to consultations with patients.

b His PDP must be approved by his responsible officer (or their nominated deputy)

c He must give the GMC a copy of his approved PDP within three months of these substantive conditions becoming effective.

d He must give the GMC a copy of his approved PDP on request.

e He must meet with his responsible officer (or their nominated deputy), as required, to discuss his achievements against the aims of his PDP.

7 He must contact the GMC within seven calendar days of returning to the UK.

8 a He must be supervised in all of his posts by a clinical supervisor, as defined in the *Glossary for undertakings and conditions*. His clinical supervisor must be approved by his responsible officer (or their nominated deputy).

b He must not work until:

i his responsible officer (or their nominated deputy) has appointed his clinical supervisor and approved his supervision arrangements

ii he has personally ensured that the GMC has been notified of the name and contact details of his clinical supervisor and his supervision arrangements.

15. This means that Dr Davide's registration will be subject to conditions 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.

16. Case concluded.

ANNEX A – 30/03/2026

Application to admit evidence

1. At the outset of proceedings, Mr Whittock made an application on behalf of Dr Davide, pursuant to Rule 34(1) of the General Medical Council's (Fitness to Practise) Rules 2004 (the Rules), to admit evidence. This application related to the unredacted medical records and history of Patient A, redacted copies of which were included within the hearing bundle.

2. The Tribunal was provided unredacted copies of the medical records in order to consider the application and reach its determination.

Submissions

On behalf of Dr Davide

3. Mr Whittock submitted that the redacted portions of Patient A's medical records were matters that he wished to cross-examine Patient A on and should be unredacted and put before the Tribunal. He submitted that these medical records have been seen by the expert witnesses and that it was important to know how the account of Patient A's medical history given by her to Dr Davide compared to the actual medical records in order to consider the matter of informed consent.

4. Mr Whittock submitted that he intended to take Patient A to the medical questionnaire she completed and put it to her that the account that she gave to Dr Davide, that is recorded on that form, is not consistent with the medical records. He submitted that he would not be seeking to cross-examine Patient A on the historic health matters themselves, but seeking to clarify the accuracy of the information she provided to Dr Davide in this respect.

On behalf of the GMC

5. Mr Taylor submitted that the redacted portions of the medical records relate to the historic health issues of Patient A and were simply not relevant to the issues that the Tribunal would have to decide. He submitted that these were very intrusive, personal medical issues which play no part in the subject matter of this hearing.

6. Mr Taylor submitted that the approach should be proportionate and that it was a matter of sensitivity and of Patient A's dignity and privacy. He submitted that the Tribunal should consider whether it was really necessary for Patient A to be cross-examined about personal, sensitive medical issues which have no relevance.

The Tribunal's Decision

7. The Tribunal reminded itself of Rule 34(1) of the Rules which states that:

> *'34(1) The Committee or a Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law.'*

8. The Tribunal considered that the evidence in question was relevant as what was discussed between Patient A and Dr Davide was a live issue in this case and related to the Allegation.

9. The Tribunal was of the opinion that to admit the evidence would be fair to Dr Davide and would not pose any injustice or unfairness to the GMC.

10. In reaching its decision the Tribunal was mindful of the concerns of the GMC regarding Patient A having to answer unnecessary and irrelevant questions in relation to her medical history. It was satisfied that as a professional Tribunal it could manage the cross-examination to ensure that the matters put to Patient A pertained to the Allegation and did not go beyond the scope of the case.

11. It also noted that it had been agreed that Patient A would be anonymised throughout the proceedings.

12. Accordingly, the Tribunal determined to grant the application.