PUBLIC RECORD

Dates: 30/05/2023 - 07/06/2023

Medical Practitioner's name:	Dr Jose DUARTE TAVARES
GMC reference number:	7223975
Primary medical qualification:	Lic Med 1985 Universidade de Lisboa

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

Summary of outcome

Erasure
Immediate order imposed

Tribunal:

Legally Qualified Chair	Miss Debi Gould
Lay Tribunal Member:	Mr Chris Weigh
Medical Tribunal Member:	Dr Liz Ball

Tribunal Clerk:	Ms Fiona Johnston

Attendance and Representation:

Medical Practitioner:	Not present and not represented
GMC Representative:	Ms Shirlie Duckworth, Counsel

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts - 05/06/2023

Background

1. Mr Duarte Tavares qualified in 1985 from the University of Lisbon. He moved to the UK and gained full GMC registration in 2012. On 15 January 2018 Mr Duarte Tavares gained employment as a Consultant Ear, Nose and Throat ('ENT') surgeon at Southampton Treatment Centre ('STC'). He worked solely for Care UK at this Treatment Centre. His work comprised of outpatient clinics and operating lists dealing with patients requiring ENT surgery. He was one of two full-time ENT consultants employed by Care UK at STC.

2. The allegation that has resulted in Mr Duarte Tavares's hearing can be summarised as follows. On 20 January 2018 Mr Duarte Tavares consulted with Patient A and arranged that he would perform a septorhinoplasty on him. The operation occurred on 13 April 2018 after which Mr Duarte Tavares consulted with Patient A again on 19 July 2018. Instead of referring him to a specialist Rhinologist at University Southampton Hospital ('UHS') it is alleged that despite a CT scan which showed that the disease was more extensive, Mr Duarte Tavares performed a further, unsuccessful, operation on Patient A.

3. It is further alleged that on 25 January 2019, Mr Duarte Tavares saw Patient B who had a lump in the parotid gland. Instead of immediately referring Patient B to UHS in line with cancer treatment protocols, he performed an operation on Patient B. He also failed to make an adequate record of that operation and then made false statements in a referral letter to UHS about what he had done to create the false impression that he had provided appropriate care to Patient B when he had not. It is alleged that his actions in this regard were dishonest.

<u>Events which led to the investigation</u>

4. On 29 May 2019, STC received a letter from University Hospital Southampton ('UHS') raising concern over the management of Patient B and reminding the STC that it should not be operating on any Head and Neck cases or cancer cases. This was discussed with the Secondary Care ENT Clinical Director (CD), Mr E, on 17 June 2019. Mr E visited STC on 24 June and met with Mr Duarte Tavares to discuss the concerns. The STC Medical Director then spoke to the Secondary Care Medical Director and a Serious Incident ('SI') call was arranged for 26 June at which a Root Cause Analysis ('RCA') was commissioned. A second letter about Mr Duarte Tavares arrived on 14 June regarding Patient A,

saying UHS was unhappy about the treatment this patient, also a patient of Mr Duarte Tavares, had received.

5. Mr Duarte Tavares was suspended on 27th June 2019, pending investigation. He subsequently resigned on 26th July 2019, and left Care UK on 31st October 2019.

6. The GMC received an online referral form dated 20 February 2020, completed by Mrs F, Care UK Southampton NHS Treatment Centre.

The Outcome of Applications Made during the Facts Stage

7. On the first day of the hearing the Tribunal accepted the GMC's submission that notice of hearing had been properly served on Mr Duarte Tavares pursuant to Rule 40 of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'). The GMC then applied to proceed in the absence of Mr Duarte Tavares pursuant to Rule 31. The Tribunal granted this application. The Tribunal's full decision on the application is included at Annex A.

The Allegation and the Doctor's Response

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

Patient A

1. On 19 July 2018 you consulted with Patient A following the septorhinoplasty you performed on 13 April 2018 and you failed to refer Patient A to a rhinologist. To be determined

2. On 17 August 2018 you performed a functional endoscopic sinus surgery and polypectomy on Patient A and:

    a. this was not indicated as it did not address the extent of the disease found namely:

        i. nasal polyps; To be determined

        ii. mucocele; To be determined

        iii. chronic sinusitis; To be determined

    b. you inappropriately attempted to open Patient A's frontonasal duct when you did not have the:

        i. necessary equipment; To be determined

        ii. training or skill to do so. To be determined

Patient B

3. On 25 January 2019 you consulted Patient B and you failed to:

a. arrange a fine needle aspiration cytology or core biopsy on Patient B's lump in the parotid gland; To be determined

b. make an adequate record of the consultation. To be determined

4. On 2 February 2019 you operated on Patient B ('the Operation') and:

a. it was inappropriate to do so without reasonable efforts to have established a diagnosis; To be determined

b. your surgical technique was inadequate because:

i. your incision was too small as it only gave you limited access; To be determined

ii. you failed to:

1. identify the main facial nerve branch; To be determined

2. excise the entire mass; To be determined

c. you failed to make an adequate record of the Operation in that you falsely described it as being an excision when only a small portion of the tumour was removed. To be determined

5. On or around 14 February 2019 you referred Patient B to University Hospital of Southampton and in your referral letter you:

a. falsely referred to a history of infection which is not recorded by Patient B's GP; To be determined

b. falsely described the Operation as a biopsy; To be determined

c. falsely stated that there was a tumour lying deeper than the facial nerve, or words to that effect, when this was not reflected in the Operation note; To be determined

d. did not mention that although you had obtained consent from Patient B for a superficial parotidectomy, you had been unable to complete this procedure during the Operation. To be determined

6. Your actions as described at paragraphs:

a. 4c were untrue as you knew you did not excise the whole tumour; To be determined

b. 5a were untrue as you knew that no history of infection had been recorded by Patient B's GP; To be determined

c. 5b were untrue because the Operation was not a biopsy; To be determined

d. 5c were untrue because there was no evidence that the tumour was lying deeper than the facial nerve; To be determined

e. 5b, 5c and 5d created a false impression in order to cover up:

i. your inadequate surgical technique described at paragraph 4b; To be determined

ii. that you had been unable to complete the superficial parotidectomy. To be determined

7. Your actions as described at paragraph:

a. 4c were dishonest by reason of paragraph 6a; To be determined

b. 5a were dishonest by reason of paragraph 6b; To be determined

c. 5b were dishonest by reason of paragraphs 6c and 6e; To be determined

d. 5c were dishonest by reason of paragraphs 6d and 6e; To be determined

e. 5d were dishonest by reason of paragraph 6e. 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

The Facts to be Determined

8. In light of the above, the Tribunal then determined the disputed allegations.

Evidence

9. The Tribunal received oral evidence on behalf of the GMC from the GMC expert witness, Professor C, consultant in Otolaryngology-Head and Neck Surgery at Manchester Royal Infirmary and at the Christie Hospital, Manchester. He confirmed the contents of his two reports, dated 23 August 2021 and 17 January 2022 and corrected several typographical errors in those reports. He was asked a number of questions by the Tribunal. He was then re-examined by Ms Duckworth on behalf of the GMC.

Witness statements

10. The Tribunal also received documentary evidence provided by the parties. This included but was not limited to Professor C's two expert reports, the consultation and operation notes created by Mr Duarte Tavares, the Care UK report, the referral letters for each Patient prepared by Mr Duarte Tavares, the Root Cause Analysis, Interview notes and Mr Duarte Tavares' response to draft rule 15 allegation.

11. The Tribunal also relied on written witness statements on behalf of the GMC:

- Dr D, consultant Otolaryngology ('ENT') Surgeon at University Hospital Southampton ('UHS') dated 19 August 2021;

- Mr E, Consultant Ear Nose and Throat ('ENT') Surgeon and Care UK ENT Clinical Director. dated 9 September 2021.

Professor C

12. With regards to Patient A, Professor C explained to the Tribunal that the operation undertaken by Mr Duarte Tavares on 19 July 2018 and described by him as functional endoscopic sinus surgery [FESS], was not indicated. This was because of the findings of a CT scan which was reported on 28 June 2018. Professor C explained that the CT scan showed significant disease such that the FESS was inappropriate and dangerous. He stated that Patient A and Mr Duarte Tavares were "lucky" that Patient A did not suffer harm as a result of that operation. Furthermore, in Professor C's opinion, Mr Duarte Tavares was not qualified to carry out the operation, lacked the appropriate equipment and training to undertake it and should not have undertaken it in any event in the setting of a treatment centre.

13. Professor C stated that the CT scan *'showed clear features of pansinusitis with polyposis and a mucocele'* with dehiscence (severe thinning) of the bone. Professor C explained that this means that the barrier between where the surgeon was operating and the dura (the membrane) around the brain was very thin making surgery in that area extremely dangerous. Professor C also said that, in his opinion, the operation undertaken by Mr Duarte Tavares was not indicated, due to the extent of the disease, the Patient was not informed of the potential risks of the surgery and any operation was unquestionably something that only a specialist surgeon would do in a teaching hospital type setting with image guidance. In particular a piece of equipment known as '*CT Navigation'*, was not available at the STC. This equipment was required to perform the operation safely. He told the Tribunal that any standard ENT surgeon would know that that they should not carry out an operation like that given the extent of the disease shown on the CT scan. Professor C stated that Mr Duarte Tavares told Care UK that he was aware of the mucocele from the CT scan.

14. Professor C said that Patient B presented to the STC with a lump in the left side of his neck. Mr DuarteTavares triaged Patient B on 25 January 2019. His consultation notes record that he decided to perform a superficial parotidectomy although the information from the referring GP and the scan which accompanied the referral indicated that the lump may be malignant.

15. On 2 February 2019 Mr Duarte Tavares operated on Patient B. Instead of performing a superficial parotidectomy, he undertook what Professor C said could be described as an incision

biopsy. However, said Professor C, in his contemporaneous operation notes, Mr Duarte Tavares described the surgery as being an excision, which meant that he had removed the whole lump (mass).

16. During that operation, Mr Duarte Tavares took samples which he sent to Histology. On 11 February the samples were reported on. Two of the samples were clear, however, Histology reported that the third sample had been taken from the periphery of what they concluded was a malignant tumour (described as a mucoepidermoid carcinoma - a minor salivary gland malignancy). Histology was unable to grade the tumour from that sample.

17. Professor C stated that following receipt of the histology report, Mr Duarte Tavares wrote a referral letter to the Multi-Disciplinary Team (MDT) at UHS dated 14 February 2014. In it Mr Duarte Tavares asserted that he had performed an incision biopsy with removal of superficial mass but stopped because the tumour was deeper than the facial nerve. He stated he was referring the case on because biopsy of the samples showed carcinoma.

18. Professor C said that no surgery should have been undertaken at all because of the potential cancer diagnosis and the protocols and guidelines surrounding proper management of such cases. It was cancer surgery which should only be undertaken by a cancer specialist following referral to the MDT.

19. Furthermore, based upon Mr Duarte Tavares' description to Care UK of the surgical technique he had employed, Professor C said that the surgery Mr Duarte Tavares had performed was inadequate, inappropriate and potentially dangerous. He also stated that it would have afforded limited access to the tumour, made its complete excision impossible and risked '*seeding*' the cancer in the surrounding healthy tissue.

20. Professor C said that the patient had been consented for one operation (superficial parotidectomy), and the operation notes asserted that Mr Duarte Tavares had excised (completely removed) the tumour but the referral letter completely contradicted that saying that Mr Duarte Tavares had only performed an incision biopsy. This raised issues of probity. Professor C explained that although the operation notes recorded that the entire tumour was removed, the referral letter gave the impression that Mr Duarte Tavares had abandoned the operation to excise the lump because he discovered that the tumour lay deep below the facial nerve.

21. Professor C told the Tribunal that Mr Duarte Tavares was later challenged about what had occurred and the various discrepancies in the records by his Clinical Director, Mr E and during the Care UK investigation. Mr Duarte Tavares tried to justify his decision not to remove the lump by stating that because of where he asserted it lay in relation to the facial nerve, a total parotidectomy would have been required for which no prior consent had been obtained.

22. Professor C told the Tribunal that Fine Needle Aspiration ('*FNA*') is a primary diagnostic tool where cancer is suspected. FNA must be undertaken before any attempt to operate where cancer of the parotid gland is suspected to secure an accurate diagnosis. Mr Duarte Tavares had not arranged for a FNA before operating on Patient B. He had simply arranged for the patient to come in within a very short space of time for superficial parotidectomy. Professor C said that Mr Duarte Tavares had been negligent in recommending and offering the patient this surgery without further investigations first. Had the lump been benign, Professor C said, operating was unnecessary; an unnecessary operation creates a risk of harm to a patient. Had it been malignant, the operation itself was potentially harmful as it could have caused the cancer to spread. In any event, said Professor C, an

operation to remove a suspicious lump in the neck should only have been done by a cancer surgeon which Mr Duarte Tavares was not, and under the supervision of the MDT at UHS, not at STC.

23. Professor C then explained what is required to perform a superficial parotidectomy. A large incision (*a 'Blair' incision*) is made which allows the facial nerve to be identified and enables the upper lobe of the parotid gland to be removed.

24. Professor C said that during the operation on 19 July, Mr Duarte Tavares only made a small incision in front of the Patient B's ear and '*sort of poked at it and took some bits of tissue around it*'. The incision he made, said Professor C, was too small to be able to undertake the planned operation which requires a bigger incision (a *'modified Blair'* incision) which extends behind the ear lobe and into a crease in the neck below the jaw line. Professor C said that the operation Mr Duarte Tavares performed was an incision biopsy during which he cut into the lump and removed three samples. One of the samples was taken from the periphery of the tumour and could have caused cancer cells to be seeded elsewhere, spreading cancer into the surrounding tissue. He said that this is why, generally speaking, doctors avoid incision biopsies for cancer at all costs unless absolutely necessary and why other investigations, and in particular FNA, must be done first.

25. Professor C also explained that although in the referral letter, which was sent after the biopsy results had been received, Mr Duarte Tavares said he decided to do a biopsy by intention and that he did not exercise the entire mass because it went deep into the facial nerve. This was not reflected anywhere in the operation notes. As Mr Duarte Tavares had not offered any clinical explanation for the different records, it raised an issue of probity. In his opinion it gave the appearance that Mr Duarte Tavares was attempting to justify his poor decision making and actions after the event because of the need for onward referral following the histological results.

The Tribunal's Approach

26. In reaching its decision on facts, the Tribunal reminded itself that the burden of proof rests on the GMC and it was for the GMC to prove the Allegation. Mr Duarte Tavares did not need to prove anything. The standard of proof was that applicable to civil proceedings, namely the balance of probabilities, i.e., whether it was more likely than not that the events occurred as alleged.

27. Where relevant to its decision-making process, the Tribunal had regard to the test for dishonesty set out in *Ivey v Genting Casinos (UK) Limited (t/a Crockfords Club) [2017] UKSC 67*, as confirmed in *Barton and Booth v R [2020] EWCA Crim 575*:

> 'When dishonesty is in question the fact-finding Tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge e or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.'

28. Mr Duarte Tavares was not present or represented at the hearing. The absence of Mr Duarte Tavares from these proceedings is a neutral matter and no adverse inference is drawn from his non-attendance. The case is to be considered entirely on the evidence before the Tribunal including any explanations provided by Mr Duarte Tavares during the Care UK investigation and to the GMC.

The Tribunal's Analysis of the Evidence and Findings

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

30. The Tribunal reminded itself of paragraphs 14, 15 and 16 of General Medical Council 'Good Medical Practice', April 2019,

> *14 You must recognise and work within the limits of your competence.*
>
> *'15 You must provide a good standard of practice and care. If you assess, diagnose or treat Patients, you must:*
>
> *a. adequately assess the Patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the Patient*
>
> *16. In providing clinical care you must….*
>
> *b. provide effective treatments based on the best available evidence;*
>
> *d. consult colleagues where appropriate.*

Paragraph 1

31. The Tribunal reviewed the consultation and operation notes for Patient A, the Care UK investigation records and findings and the evidence of Professor C. These show that on 25 January 2018 Mr Duarte Tavares consulted with Patient A and booked him for a septorhinoplasty to correct deviation of his nasal pyramid and septum caused by a blow 12 months earlier.

32. The notes also showed that on 13 April Mr Duarte Tavares performed the septorhinoplasty on Patient A. When the surgery failed to resolve Patient A's condition, Mr Duarte Tavares saw Patient A again on 31 May and ordered a CT scan. He further consulted with Patient A on 19 July 2018 and referenced the results of the CT scan, taken on 26 June, in the consultation record. However, Mr Duarte Tavares only stated that the scan showed a septal perforation, nasal polyps and pansinusitis. He then scheduled a further operation, namely a Functional Endoscopic Sinus Surgery (FESS) and a polypectomy which he undertook on 17 August 2018.

33. On 26 September, when Patient A's condition was not better, Mr Duarte Tavares referred Patient A to UHS stating he required a further operation for complicated polyps which required equipment and expertise not available at the STC.

34. The Tribunal accepted the evidence of Professor C that because the CT scan showed pansinusitis, polyposis and a large right front sinus mucocele with dehiscence of the superior-medial wall of the right orbit there was a very thin barrier between the front sinus and the dura surrounding the brain. The Tribunal also accepted Professor C's opinion that the extent of the disease mandated onward referral to Southampton University Hospital (SUH) because any operation to the frontal sinus carried significant risk to Patient A. Professor C was clear, and the Tribunal accepted, that as a result any operation should only have been undertaken by a specialist surgeon (a Rhinologist), in an appropriate clinical setting (in Professor C's opinion this meant a teaching hospital) using appropriate surgical equipment including in particular '*CT Navigation*'. Finally the Tribunal accepted Professor C's evidence that Mr Duarte Tavares and Patient A were "lucky" that none of the risks associated with surgery materialised and that Patient A had not been made aware of those risks before it was performed.

35. The Tribunal concluded that Professor C was a compelling witness. He set out his findings and conclusions logically and carefully and clearly explained the multiple inconsistencies in the records and documents created by Mr Duarte Tavares and his subsequent accounts of events.

36. Having regard to the duties established by paragraphs 15 – 17 inclusive of Good Medical Practice and the evidence of Professor C, the Tribunal concluded that Mr Duarte Tavares should have referred Patient A to a Rhinologist but failed to do so.

37. The Tribunal found Paragraph 1 of the Allegation proved.

Paragraph 2a (i)

38. The Tribunal noted that in his report, Professor C stated that the CT scan showed clear features of pansinusitis, extensive polypoidal disease and chronic sinusitis with mucocele formation and adjacent bone erosion/thinning including that of the skull base. He explained that the finding of the mucocele suggested a more complicated and wider extent of disease and meant any operation should be performed by a Consultant Rhinologist.

39. Professor C explained that Patient A later required further operations at SUH to resolve matters.

40. The Tribunal further noted that Mr E, the Clinical Director at STC, during the Care UK investigation stated that there was no clear plan to address the mucocele and Mr Duarte Tavares had not mentioned this in his consultation or operation notes. This contrasted with Mr Duarte Tavares' account in the interview with Care UK, when he accepted knowing about the mucocele.

41. The essence of Professor C's evidence is that taken in conjunction with each other, the various diagnoses and the risks inherent in the surgery required to address them, the correct procedure to address the extent of the disease was referral to a specialist in a specialist facility with specialist equipment. Instead, Professor C explained in his report, the operation that Mr Duartes Tavares arranged was very basic/limited endoscopic surgery which did not address the extent of the disease found and put the patient at risk of harm. That surgery was therefore not indicated.

42. Based upon Professor C's evidence, the comments of Mr E to Care UK and Mr Duarte Tavares' contemporaneous consultation and operation notes, the Tribunal concluded that the extent of each diagnosis meant that the operation arranged by Mr Duarte Tavares was not indicated. Additionally,

however, Mr Duarte Tavares told Care UK that he was aware of extent of the disease, and in particular of the mucocele, but proceeded to arrange basic endoscopic surgery instead of specialised surgery using appropriate equipment which could have resolved Patient A's issues properly. Without the specialisation, equipment and setting required, the Tribunal concluded that the proposed surgery could not have addressed the extent of each disease. For all the reasons stated, the Tribunal found paragraph 2(a)(i), (ii) and (iii) proved.

Paragraph 2b (i)(ii)

43. The Tribunal then considered whether Mr Duarte Tavares inappropriately attempted to open Patient A's frontonasal duct when he did not have the necessary equipment or training or skill to do so.

44. Professor C described Mr Duarte Tavares as a general ENT surgeon.

45. In his interview with Care UK, despite what was stated in the surgical records, Mr Duarte Tavares stated that he knew about the mucocele and attempted to open up the frontonasal duct (access to the frontal sinus). The Tribunal accepted the evidence of Professor C that this showed that Mr Duarte Tavares was aware of the complicated nature of the situation but carried on and performed very basic endoscopic sinus surgery. This was regardless of the fact that he did not have the necessary equipment, skills or training, and in particular did not have access/or use of CT navigation which was required to confirm the location of critical structures. Consequently, Professor C stated, the operation placed Patient A at risk of harm.

46. The Tribunal accepted the evidence of Professor C that the CT scan showed that Patient A had clear features of pansinusitis with polyposis and a mucocele. Having already determined that Mr Duarte Tavares should therefore have referred Patient A to a Rhinologist but instead carried out the surgery, the Tribunal determined that Mr Duarte Tavares did not have the necessary training or equipment to open Patient A's frontonasal duct. Mr Duarte Tavares is not a Rhinologist. Professor C also said the fact that Mr Duarte Tavares chose to perform the operation in the setting and with the equipment available indicated that he lacked the necessary training and skills required. Therefore, the Tribunal found paragraph 2 proved in its entirely.

Patient B

Paragraph 3a

47. The Tribunal reminded itself of the duty in GMP paragraph 16b GMP which states:

16 In providing clinical care you must:

b. provide effective treatments based on the best available evidence

48. The Tribunal considered whether Mr Duarte Tavares was required to arrange a fine needle aspiration cytology or core biopsy on Patient B's lump in the parotid gland (the lump in the neck).

49. The Tribunal noted that in his expert report Professor C stated:

> *'The standard of care when assessing a Patient with a parotid lump is to perform a diagnostic biopsy, usually fine needle aspiration cytology. This is important because this helps inform the next treatment steps and their urgency.'*

50. Professor C said that if malignancy was indicated by the results of a FNA, this required urgent medical intervention. If, however, it was benign no operation was required, and a patient would avoid surgery with the risks which that entailed.

51. The Tribunal also reminded itself of the contents of the email sent by Mr E to Care UK in which he described FNA as '*necessary before definite surgery*' (sic) and that *'tumour seeding during any surgical approach is a very significant risk*'. Both he, and Care UK, referred in this regard to the Head and Neck Cancer Multidisciplinary Management Guidelines, 2011.

52. The Tribunal noted that in his preoperative Outpatient Consultation report dated 25 January 2019, Mr Duarte Tavares had not even considered carrying out a fine needle aspiration on Patient B. Finally, the Tribunal referred to Mr Duarte Tavares' email date 19 March 2023 to the GMC responding to the draft allegations:

> *"Yes I do agree, should have asked for a needle biopsy, as to the record I do not remember."*

53. For the reasons set out above the Tribunal found paragraph 3a proved.

Paragraph 3b

54. The Tribunal concluded that Mr Duarte Tavares had accepted that he had failed to arrange a FNA. Taken as a whole, the Tribunal determined that Mr Duarte Tavares had not followed appropriate Guidelines and standard clinical practice in relation to the finding of a lump in the parotid gland and found Paragraph 3a of the Allegation proved.

55. The Tribunal considered whether Mr Duarte Tavares had made an adequate record of Patient B's consultation on 25 January 2019 when he saw Patient B in clinic for the first time. The Tribunal noted that the only record of that consultation was that Mr Duarte Tavares had made a diagnosis of '*left parotid lesion*' and that he had booked surgery (a superficial parotidectomy).

56. The Tribunal had regard to paragraph 19 of GMP which states:

> ***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*

57. The Tribunal also had regard to paragraph 21 of GMP which sets out the information which clinical records should contain.

58. Further the Tribunal noted the outcome of the Care UK Investigation report which described Mr Duarte Tavares' records generally as being '*poor…very brief*' and noted that there were discrepancies between contemporaneous records, onward referral letters and his statement to inform the RCA.

59. The Tribunal also took into account Professor C's expert report which stated that he could not assess the quality of Mr Duarte Tavares examination of Patient B as '*there is no record keeping of the examination*' and his comment that there are '*significant issues*' with Mr Duarte Tavares record keeping. Mr Duarte Tavares asserted to Care UK that he had made records but had experienced software issues. When checked, no software issues were found and Care UK established that had any entries been made in the electronic record keeping system (Proxima), they would have been preserved and would be accessible. No records additional to those contained within the Clinical Records Bundle were found.

60. The Tribunal was satisfied that Mr Duarte Tavares did not make an adequate record of the consultation and found paragraph 3b proved.

Paragraph 4a

61. The Tribunal considered whether Mr Duarte Tavares had operated on Patient B on 2 February 2019 without taking reasonable efforts to have established a diagnosis.

62. The Tribunal noted that Mr Duarte Tavares operated before the nature of the lump was known, the histology only occurring after the operation and as a result of samples taken during it.

63. The Tribunal had regard to Professor C's report in which he states,

> '*In this situation, DT did not know the diagnosis and it was potentially therefore malignant. It was inappropriate for anyone to be operating on Patient B until a diagnosis had been made (or at least attempted).'*

64. The Tribunal also took into account the witness statement of Mr Attila E which reads,

> *'Not going for a FNA is not justifiable. Even if you don't get an exact diagnosis or if the lab say it is insufficient or suggest repeating the FNA, the risk of losing the opportunity to get a firm diagnosis before deciding on the treatment is not defendable.'*

65. The Tribunal have already found that Mr Duarte Tavares failed to arrange a fine needle aspiration to assess the nature of the lump. It considered that good medical practice as well as well established guidelines as to the treatment of cancer patients require medical practitioners to use diligence, care, knowledge, skill and caution in administering treatment to a patient. Therefore, doctors need to take care to ensure they investigate appropriately when considering operating on a patient.

66. Mr E explained to Care UK that he had explained to Mr Duarte Tavares the remit of the care which the STC could provide. Mr Duarte Tavares had also been provided with an induction when this was re-iterated. He was told that Head and Neck cases should be referred to the MDT. A lump in the parotid gland would fall within that category.

67. When asked by Care UK to explain why he had proceeded to operate, Mr Duarte Tavares stated that the patient wished him to do so as he did not wish to wait. This is not in accordance with the clinical notes which make no reference to discussions with Patient B in this regard.

68. The Tribunal concluded that there was clear evidence before it that Mr Duarte Tavares should have not proceeded with the operation and found paragraph 4a proved.

Paragraph 4b (i) &(ii)

69. The Tribunal considered whether the surgical technique used by Mr Duarte Tavares in the surgery which he performed on Patient B on 2 February 2019 was inadequate because the incision was too small, he failed to identify the main facial nerve branch and he failed to excise the tumour.

70. The Tribunal noted that in his contemporaneous surgical record, Mr Duarte Tavares stated that he had excised the entire tumour. The samples which he took during the operation were examined by histology after the surgery and showed that one of the samples had been taken from the periphery of the tumour and the other two samples were clear. Following receipt of the histology report, Mr Duarte Tavares referred Patient B to the MDT. Subsequently, the entire tumour was removed at SUH and Patient B received additional treatment in relation to the malignancy.

71. The Tribunal found as a fact that the evidence, including the referral letter written by Mr Duarte Tavares, establishes that he did not excise the tumour during the operation.

72. Furthermore, the Tribunal noted Mr Duarte Tavares' response to this allegation contained in his email to the GMC. He stated that he had not used a Blair incision but a facelift incision. He said he had identified that the main trunk of the facial nerve was inside the tumour and had stopped operating because the patient had not consented for the total parotidectomy, which those findings would have required.

73. The Tribunal noted that the surgical records showed that Mr Duarte Tavares used a small skin incision although in his email response to the GMC he stated *'I usually do not use the Blair….but a facelift incision. In this case I do not remember precisely what I did*'. He made no reference in his surgical notes to identifying the main facial nerve branch. Professor C stated that the operation which Mr Duarte Tavares in fact performed was an incision biopsy, to which Patient B had not consented. Professor C also pointed out that the contemporaneous surgical notes state that Mr Duarte Tavares had excised, which Professor C stated means completely removed, the mass. He explained that the fact that Mr Duarte Tavares had only made a small incision indicated he was never going to do the superficial parotidectomy.

74. The Tribunal accepted Professor C's careful and considered responses in which he explained that the various records, referral letters and explanations provided by Mr Duarte Tavares were inconsistent with each other and could not therefore be relied upon.

75. The Tribunal noted that it was only after receipt of the histology report, which showed that the lump was malignant, that Mr Duarte Tavares stated that rather than excising the mass, he had been unable to do so because the tumour lay deep below the main facial nerve.

76. The Tribunal accepted Professor C's oral evidence that Mr Duarte Tavares changed his account when challenged to justify his actions. Consequently, the Tribunal rejected Mr Duarte Tavares assertions as to what he did, what he could see, where he believed the tumour was located and why he did not proceed with the intended operation. The Tribunal concluded that the incision which Mr

Duarte Tavares made was so small that the entire tumour could not be removed, that he did not properly identify the main facial nerve and that he did not excise the tumour.

77. For the reasons stated, the Tribunal found Allegation 4(b) proved in its entirety.

Paragraph 4C

78. The Tribunal considered whether Mr Duarte Tavares failed to make an adequate record of the operation. The Tribunal has already found that the incision was too small to remove the whole mass. It also noted the oral evidence of Professor C that Mr Duarte Tavares had only removed 3 pieces of tissue which he sent to histology. It also noted the referral letter in which Mr Duarte Tavares states '*We did an incision extended biopsy with removal of superficial mass and stopped…..*'

79. The Tribunal concluded that Mr Duarte Tavares did not make an adequate record of the operation he performed. He falsely described the nature of the procedure which he had undertaken and stated in his notes that he had excised the tumour when this was incorrect. The Tribunal concluded that his operation note was false in that he knew that his surgical technique was such that he could not, as he stated in the record of the operation, have removed the whole of the tumour. The Tribunal concluded that regardless of the description be applied to the intended operation prior to surgery commencing, Mr Duarte Tavares did not undertake that operation or the operation which he claimed in the operation note that he had undertaken. The Tribunal accepted Professor C's evidence that the operation was an incision biopsy. Accordingly, the Tribunal concluded that Mr Duarte Tavares record of the operation was inadequate and therefore found paragraph 4c proved.

Paragraph 5a

80. The Tribunal then considered whether Mr Duarte Tavares had falsely referred to a history of infection, which is not recorded by Patient B's GP, in the referral letter he sent to the MDT at SUH dated 14 February 2018. The letter was sent following receipt of histological examination of the samples he had taken during the operation on 2 February 2018, reported on 11 February 2018. The Tribunal noted that there is a history of infection recorded by the GP. Therefore, the Tribunal found paragraph 5a not proved.

Paragraph 5b

81. The Tribunal considered whether Mr Duarte Tavares falsely described the operation undertaken as a biopsy in the referral letter to the SUH.

82. The Tribunal had regard to Professor C's report:

> *'The operation note states that the mass was excised; yet it is known that only a small portion of tumour was removed. It does appear that, upon looking at the pathology report, DT then changed his record of events in suggesting he stopped exploring the tumour because it was deep to the temporal branch of the facial nerve and described the operation as an extended incisional biopsy, with the suggestion of that being the planned intent.'*

83. The Tribunal also took into consideration Mr Duarte Tavares' email response:

'if I did not complete the surgery why is it wrong to describe it as a biopsy?'

84. In his oral evidence, Professor C stated that there was no evidence that the operation Mr Duarte Tavares intended to perform, namely a superficial parotidectomy, was commenced or undertaken because of the surgical technique which was used.

85. The Tribunal accepted Professor C's conclusion in his expert reports and his oral evidence that Mr Duarte Tavares changed his description of the operation from how it was described in his surgical records to how he described it in the referral letter.

86. However, when asked what operation Mr Duarte Tavares in fact performed, Professor C stated that it could best be described as an incision biopsy.

87. The Tribunal concluded that although in the referral letter Mr Duarte Tavares had described the surgery as a biopsy to explain and justify his poor decision making and to cover up that he had not removed the lump following the histology report, it was correct to refer to the surgery as a biopsy. Therefore, the Tribunal found paragraph 5b not proved.

Paragraph 5c

88. The Tribunal then considered whether Mr Duarte Tavares falsely stated that there was a tumour lying deeper than the facial nerve when this was not reflected in the operation note.

89. The Tribunal has already concluded that the contemporaneous record of the operation was false. Furthermore, that the explanation provided by Mr Duarte Tavares of what he did in the referral letter was to justify his poor decision making in proceeding to operate without first undertaking a FNA. Further the Tribunal has accepted that by its nature a biopsy involves a small, limited incision. Accordingly, while the Tribunal accepts the description of the surgery as a biopsy, it does not follow that the Tribunal accepts the accuracy of the assertion about why the lump was not excised, namely that it was lying deeper than the facial nerve. It does, however, follow that in the referral letter, Mr Duarte Tavares did not accurately set out what was reflected by his surgical notes. For this reason alone, his assertion in the referral letter was false.

90. However, the Tribunal also noted that in his written report Professor C stated:

'I am not sure that there was any evidence that the tumour was indeed lying deeper than the facial nerve, but one assumes that the doctor is trying to provide an explanation as to why he did not remove it. It is clearly not reflected in the operation note. It would be standard to record all findings accurately in an operation note. As to why the operation note glossed over the fact that the nodule was not excised as implied; was removed in piecemeal; and gross tumour was left behind at the end of the operation is unknown. This level of dishonesty is a serious issue for a medical practitioner.'

91. The Tribunal noted that the ultrasound scan showed that the mass was not deep. Professor C's evidence was the incision which Mr Duarte Tavares made was inadequate for him to have made a proper assessment of the location of the mass and that he did not do so. Accordingly, the Tribunal concluded that the assertion in the referral letter was also inaccurate and false because Mr Duarte Tavares did not know where specifically the tumour was located specifically in relation to the facial nerve. Therefore, the Tribunal found paragraph 5c proved.

Paragraph 5d

92. The Tribunal then considered whether in the referral letter, Mr Duarte Tavares had mentioned that although he had consent from Patient B for a superficial parotidectomy, he had been unable to complete this procedure.

93. The Tribunal noted that the consent form was for superficial parotidectomy surgery. It also noted that the referral letter made no mention of that procedure. The contemporaneous medical notes and the surgical notes contain no record of anyone obtaining consent for a biopsy nor that Patient B was advised that attempts to remove the tumour had been unsuccessful. Professor C's report stated that the referral letter suggests only that an exploratory biopsy was planned and undertaken.

94. Professor C's evidence was compelling. He pointed again to the inconsistencies and discrepancies across the medical records, referral letter and subsequent explanations provided by Mr Duarte Tavares. Namely, the contemporaneous consultation record indicated the intention to undertake a parotidectomy, the operation notes said the mass had been excised, pathology showed piecemeal removal of a tumour and the referral letter suggested an exploratory biopsy. There was, however, no explanation that the planned operation was aborted and transitioned into a completely different operation. Therefore, the Tribunal finds paragraph 5d proved.

Paragraph 6 a- e (i)(ii)

95. In considering paragraph 6, the Tribunal took into account its earlier findings. For the reasons set out above, the Tribunal has determined that paragraphs 6a and 6d were found proved.

96. In relation to 6e(i) and 6e(ii) the Tribunal also found these to be proved, however only in relation to the assertions made in 5c and 5d. This is because 5b was not proved.

97. Paragraph 6b and 6c are not proved.

Paragraph 7

98. In considering paragraph 7, the Tribunal took into account its earlier findings. It also had regard to the directions of law regarding dishonesty.

99. Although Professor C was careful not to express an opinion as to whether Mr Duarte Tavares had acted dishonestly, he did give clear evidence which assisted the Tribunal in relation to that issue. Professor C explained that he had striven to understand Mr Duarte Tavares' clinical decision making. However, the chronology of events, inconsistent records and responses when asked to justify the clinical decision making had driven Professor C to the conclusion that these could only be explained by a lack of probity. He readily acknowledged, however, that it was for the Tribunal to determine whether or not this amounted to dishonesty.

100. The Tribunal considered Mr Duarte Tavares' emails to the GMC and his response to Mr E and Care UK. It concluded that in relation to Patient A, Mr Duarte Tavares changed his account of events to seek to justify his poor decision making and his recognition that he put Patient A at risk of serious harm by operating despite the fact that this was not indicated by the extent of his disease. In relation

to Patient B, the Tribunal has concluded that Mr Duarte Tavares changed his account of events to justify his poor decision making and failure to adhere to proper Guidelines.

101. The Tribunal also considered the evidence given to Care UK by Mr E. When he challenged Mr Duarte Tavares about his decision making in relation to the use of an endoscope, Mr Duarte Tavares said the Guidelines were *'only Guidelines'.* Mr Duarte Tavares also said using an endoscope would not inform his clinical decisions. Mr E had to persuade Mr Duarte Tavares to change his clinical behaviour to align with best practise. The Tribunal also noted that Mr Duarte Tavares had indicated his desire to undertake operations which were outside the remit of the STC and which he recognised required managerial approval. The Tribunal found this evidence telling. The Tribunal concluded that Mr Duarte Tavares demonstrated a cavalier approach in relation to both patients and did not recognise the correct limits of his remit or ability.

102. Having regard to all of the evidence, the Tribunal concluded that Mr Duarte Tavares would have recognised his behaviour in relation to paragraphs 7a, 7d and 7e was dishonest and ordinary decent members of the public would also regard them as being so. Accordingly, and for the reasons set out above, the Tribunal has determined that paragraphs 7a, 7d, 7e were found proved. It follows that applying the same rationale, the Tribunal has found Paragraphs 7b and 7c not proved.

The Tribunal has determined the facts as follows:

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

Patient A

1. On 19 July 2018 you consulted with Patient A following the septorhinoplasty you performed on 13 April 2018 and you failed to refer Patient A to a rhinologist. Found proved

2. On 17 August 2018 you performed a functional endoscopic sinus surgery and polypectomy on Patient A and:

    a. this was not indicated as it did not address the extent of the disease found namely:

        i. nasal polyps; Found proved

        ii. mucocele; Found proved

        iii. chronic sinusitis; Found proved

    b. you inappropriately attempted to open Patient A's frontonasal duct when you did not have the:

        i. necessary equipment; Found proved

        ii. training or skill to do so. Found proved

Patient B

3. On 25 January 2019 you consulted Patient B and you failed to:

   a. arrange a fine needle aspiration cytology or core biopsy on Patient B's lump in the parotid gland; Found proved

   b. make an adequate record of the consultation. Found proved

4. On 2 February 2019 you operated on Patient B ('the Operation') and:

   a. it was inappropriate to do so without reasonable efforts to have established a diagnosis; Found proved

   b. your surgical technique was inadequate because:

      i. your incision was too small as it only gave you limited access; Found proved

      ii. you failed to:

         1. identify the main facial nerve branch; Found proved

         2. excise the entire mass; Found proved

   c. you failed to make an adequate record of the Operation in that you falsely described it as being an excision when only a small portion of the tumour was removed. Found proved

5. On or around 14 February 2019 you referred Patient B to University Hospital of Southampton and in your referral letter you:

   a. falsely referred to a history of infection which is not recorded by Patient B's GP; Found not proved

   b. falsely described the Operation as a biopsy; Found not proved

   c. falsely stated that there was a tumour lying deeper than the facial nerve, or words to that effect, when this was not reflected in the Operation note; Found proved

   d. did not mention that although you had obtained consent from Patient B for a superficial parotidectomy, you had been unable to complete this procedure during the Operation. Found proved

6. Your actions as described at paragraphs:

a. 4c were untrue as you knew you did not excise the whole tumour; **Found proved**

b. 5a were untrue as you knew that no history of infection had been recorded by Patient B's GP; **Found not proved**

c. 5b were untrue because the Operation was not a biopsy; **Found not proved**

d. 5c were untrue because there was no evidence that the tumour was lying deeper than the facial nerve; **Found proved**

e. 5b, 5c and 5d created a false impression in order to cover up:

i. your inadequate surgical technique described at paragraph 4b; **Found proved** (as to 5c and 5d not 5b)

ii. that you had been unable to complete the superficial parotidectomy. **Found proved** (as to 5c and 5d not 5b)

7. Your actions as described at paragraph:

a. 4c were dishonest by reason of paragraph 6a; **Found proved**

b. 5a were dishonest by reason of paragraph 6b; **Found not proved**

c. 5b were dishonest by reason of paragraphs 6c and 6e; **Found not proved**

d. 5c were dishonest by reason of paragraphs 6d and 6e; **Found proved**

e. 5d were dishonest by reason of paragraph 6e. **Found proved**

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

Determination on Impairment - 07/06/2023

103. 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, Mr Duarte Tavares' fitness to practise is impaired by reason of misconduct.

The Evidence

104. The Tribunal has taken into account all the evidence received during the facts stage of the hearing. It received no further evidence at this stage of the hearing.

Submissions

105. In summary, Ms Duckworth, on behalf of the GMC, submitted that the facts found proved amount to misconduct and that Mr Duarte Tavares's fitness to practice is impaired.

106. Ms Duckworth reminded the Tribunal of the relevant paragraphs of GMP, namely, paragraphs 1, 7, 8, 14, 15, 65, 68 and 71.

107. She also referred the Tribunal to the relevant caselaw, including Cheatle *v. General Medical Council* [2009] EWCA 645) and Meadow v *General Medical Council [2006] EWCA Civ 1390.*

108. She submitted that patients need good doctors. Good doctors make the care of their patients their first concern, are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law. She further submitted the Tribunal's findings at stage one set out a number of ways in which Mr Duarte Tavares conduct breached these standards. She also submitted that doctors must be competent in all aspects of their work. She submitted that doctors must keep their knowledge and skills up to date, must recognize and work within the limits of their competence and provide a good standard of practice and care.

109. Ms Duckworth further submitted that doctors must adequately assess their patient's condition taking account of their history, their views and values, and awareness. If they examine the patient, they must promptly provide or arrange suitable advice, investigations or treatment where necessary and refer on to another practitioner where appropriate. The Tribunal particularly took account of Professor C's evidence, that Mr Duarte Tavares was lucky that Patient A did not suffer harm as a result of the operation he performed. She submitted that the Tribunal has found that Mr Duarte Tavares was not qualified to carry out the operation on Patient A and lacked the appropriate equipment and training to undertake it.

110. In relation to Patient B, she submitted that no surgery should have been undertaken at all because of the potential cancer diagnosis, that such surgery should only be undertaken by a cancer specialist and Mr Duarte Tavares' surgical technique was inadequate, inappropriate and potentially dangerous.

111. She further submitted that the operation itself was potentially harmful because it created a risk of the cancer spreading.

112. She submitted that as the Tribunal had concluded that Mr Duarte Tavares showed a lack of insight about the correct limits of his remit or ability.

113. Ms Duckworth further submitted that the Tribunal had concluded that the referral letter written by Mr Duarte Tavares contained a number of misleading statements intended to justify his poor decision making and failure to adhere to proper guidelines. Ms Duckworth submitted that this was particularly serious dishonesty as it is directly linked to the profession of medicine.

114. Ms Duckworth submitted that the test of serious misconduct is met. Mr Duarte Tavares' conduct would be considered deplorable by fellow practitioners or properly informed members of the public.

115. Ms Duckworth reminded the Tribunal that the clinical failures were not a single isolated error. She also submitted that the additional aggravating feature of the dishonesty in relation to the Patient B's care was committed to cover up his poor clinical performance. She further submitted that there is no evidence of remediation, insight or recognition of wrongdoing so that there is a risk repetition in the future.

116. Ms Duckworth submitted that a finding of impairment was also required to uphold proper professional standards and public confidence in the profession which would be undermined if a finding of impairment were not made.

The Relevant Legal Principles

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

118. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct which was serious; and secondly whether a finding of misconduct should lead to a finding of impairment.

119. With regard to impairment, the Tribunal had regard to the case of *CHRE v NMC and Grant [2011] EWHC 927* where Dame Janet Smith's observations in the Fifth Report of the Shipman Inquiry were endorsed. Dame Janet Smith suggested approaching impairment in the following way;

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> *a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> *d. has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

120. The Tribunal must determine whether Mr Duarte Tavares' fitness to practise is impaired today. The Tribunal must take into account his conduct at the time of the events and any relevant factors since then such as whether the matters are remediable, have been remedied and whether there is any likelihood of repetition. The Tribunal was also obliged to consider whether a finding of impairment was required on public interest grounds.

121. Throughout the decision-making process, the Tribunal had regard to the overarching objective in Section 1 of the Medical Act 1983, as amended, which involves the pursuit of the following objectives:

a) to protect, promote and maintain the health, safety and well-being of the public,

b) to promote and maintain public confidence in the medical profession, and
c) to promote and maintain proper professional standards and conduct for members of that profession.

The Tribunal's Determination on Impairment

Misconduct

122. In determining whether Mr Duarte Tavares' fitness to practise is currently impaired by reason of misconduct, the Tribunal first considered whether the facts found proved amounted to misconduct and whether that misconduct was serious.

123. The Tribunal considered that paragraphs 7, 14, 15, 16b, 19, 21a, 65, 68 and 71 Good Medical Practice ('GMP') were relevant in this case as follows:

7 You must be competent in all aspects of your work, including management, research and teaching.

14 You must recognise and work within the limits of your competence.

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
c. refer a patient to another practitioner when this serves the patient's needs.

16 In providing clinical care you must:

b. provide effective treatments based on the best available evidence

….

d. consult colleagues where appropriate

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

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

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

71 You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents.[22] You must make sure that any documents you write or sign are not false or misleading.

a. You must take reasonable steps to check the information is correct.
b. You must not deliberately leave out relevant information.

124. The Tribunal reviewed its factual findings and considered the question of impairment by reference to four areas: initial assessment and diagnosis (including formulation of a treatment plan), record keeping, clinical performance with regard to the operations undertaken) and referrals. The Tribunal concluded that Mr Duarte Tavares' conduct, whether considered individually or collectively, fell far below that which was expected of a competent ENT surgeon and amounted to serious misconduct.

Initial assessment and diagnosis

125. The Tribunal reminded itself that Mr Duarte Tavares had a consultation with Patient A, failed to refer him to an appropriate specialist, undertook an operation which was not indicated and put Patient A at risk of harm. The Tribunal reminded itself of the expert evidence of Professor C that this was not consistent with relevant guidance or with GMP and was seriously below the standard expected of a competent ENT doctor.

126. With regards to Patient B the Tribunal noted that Mr Duarte Tavares had failed to carry out a diagnostic biopsy by way of a FNA. The Tribunal reminded itself of the comments contained in the report of Professor C:

> *'The standard of care when assessing a patient with a parotid lump is to perform a diagnostic biopsy, usually fine needle aspiration cytology. This is important because this helps inform the next treatment steps and their urgency. In particular, if it suggests malignancy, that allows a patient to be referred and treated by a head and neck cancer team, have further forms of imaging for staging and have a definitive operation performed on an urgent basis.*
>
> *In this case, there was no effort made in order to obtain a diagnosis before operating.'*

127. The Tribunal also took into account the contents of the Care UK interview with Mr Duarte Tavares, in which he stated he was fully aware of the UK multidisciplinary Guidelines for H&N cancer. The Tribunal noted that the purpose of the FNA was to properly establish a diagnosis to inform future care. Failure to do so put patient safety at risk. Despite awareness of the guideline, Mr Duarte Tavares did not undertake a FNA. This constituted a breach of paragraph 15 of GMP (set out above). The Tribunal determined that this amounted to serious misconduct.

Recordkeeping

128. The Tribunal found that Mr Duarte Tavares' records for both Patient A and Patient B were scant, noted little in the way of examination findings and gave no insight into his decision making process or discussions with his patients around the proposed treatment plan. Professor C stated that;

> *'There are significant issues with the record keeping of DT. There appears to be no annotation made as a result of the clinic appointment of 25 01 19. If true, this represents a standard seriously below that of a competent consultation (of any speciality). The annotation can be in writing, or through dictation / computer entry (or both) – but there must be some form of contemporaneous and accurate documentation and there is none. I note that in the internal investigation, it is claimed that there was some kind of software issue. He should have checked this before operating on the Patient EM and would have had a chance to reflect and record the consultation. This falls seriously below the standard of care of a reasonably competent consultant in otolaryngology.'*

129. The Tribunal was of the view that Mr Duarte Tavares had breached paragraph 19 of GMP. Proper record keeping is a core function of good clinical practice and patient care. It is fundamental because it provides essential information for the treating doctor and any other clinicians who are involved in the patient's care. Inadequate medical records can compromise patient safety. Therefore, his actions amounted to misconduct which was serious.

130. The Tribunal determined that Mr Duarte Tavares poor decision making and poor surgical technique had placed both patients at risk of harm. The surgery undertaken on Patient A could have resulted in injury to the brain. The operation on Patient B could have caused the cancer to spread to healthy tissue. The Tribunal determined that Mr Duarte Tavares' conduct fell so far short of the standards reasonably to be expected of a doctor so as to amount to serious misconduct.

Dishonesty

131. The Tribunal next considered whether the dishonesty found proved amounted to misconduct.

132. The Tribunal determined that paragraph 65, 68 and 71 of GMP are engaged in this case.

133. The Tribunal reminded itself of its findings that Mr Duarte Tavares had acted dishonestly when he completed a referral letter which contained misleading statements and omitted relevant information. The Tribunal concluded that instead of prioritising patient safety and providing full, complete and honest information, Mr Duarte Tavares had tried to cover up his poor clinical performance and decision making.

134. The Tribunal determined that such dishonesty constitutes a breach of fundamental tenet of the profession and would be considered deplorable by fellow practitioners.

135. Having found that the facts which the Tribunal found proved amounted to misconduct, the Tribunal went on to consider whether, as a result of that misconduct, Mr Duarte Tavares' fitness to practise is currently impaired.

136. The Tribunal reminded itself of the test as to whether Mr Duarte Tavares' fitness to practice is currently impaired. This is assessed by considering how Mr Duarte Tavares had acted or failed to act in the past and also looking forwards whether they consider that Mr Duarte Tavares' ability to practise safely is compromised and/or whether public confidence in the profession would be undermined in the absence of a finding of impairment.

137. Accordingly, the Tribunal therefore looked for any evidence which showed insight, remediation and or likelihood of repetition and balanced these against the statutory objectives.

138. The Tribunal has no evidence that Mr Duarte Tavares has any insight into his failures. During the Care UK investigation, the only acknowledgement he made that he had made any form of mistake or error was his acceptance, with the benefit of hindsight, that he should have used a FNA on Patient B. In all other respects, and in his correspondence with the GMC regarding the Allegation, he sought to explain and justify his actions. The Tribunal were particularly concerned that in relation to Patient B, Mr Duarte Tavares sought to attribute responsibility to Patient B for this decision not to use FNA before operating. Although his contemporaneous records made no mention of it, Mr Duarte Tavares told Care UK that he had scheduled a superficial parotidectomy because that Patient B was agitated, wanted to get on with it and did not want to be referred to MDT. The Tribunal considered that this response confirmed Mr Duarte Tavares' lack of insight. Importantly, Mr Duarte Tavares had not acknowledged or accepted that he had put patient safety at risk by his misconduct.

139. The Tribunal drew no adverse inference from Mr Duarte Tavares' non-attendance at the hearing, however, it was open to him to make admissions to parts of the Allegation if he wished to do so. The Tribunal further determined that having no recognition of any wrongdoing and having shown no insight, Mr Duarte Tavares had not taken any action to remediate. The Tribunal therefore concluded that there was a likelihood of repetition that Mr Duarte Tavares would continue to provide poor clinical care. The Tribunal considered that Mr Duarte Tavares's actions put patients at significant risk of harm and that due to the risk of repetition, public confidence was at risk if a finding of impairment is not made.

140. The Tribunal also determined that the public are entitled to have confidence that doctors have the requisite skills, follow good practice, demonstrate good clinical judgment, act within the limits of their competency and provide appropriate and adequate treatment. The Tribunal therefore concluded that public confidence in the profession would be undermined if a finding of impairment is not made.

141. A central feature of the misconduct here is dishonesty. The Tribunal found that what Mr Duarte Tavares wrote in the referral letter in relation to Patient B was dishonest because it was intended to mislead. This is serious misconduct for the reasons set out above. In regard to that dishonest misconduct, which related to patient care and the practice of medicine, the Tribunal found no evidence of insight or remediation. Accordingly, the Tribunal concluded that there remains a risk repetition.

142. The Tribunal determined that the public expect doctors to act honesty in relation to their care and prioritise patient safety. The dishonesty in this case directly related to patient care. The Tribunal therefore also concluded that a finding of impairment was necessary to declare and uphold proper standards of behaviour.

143. Finally, the Tribunal also concluded that it would fundamentally undermine public confidence in the profession and its regulator if it concluded that, despite the dishonesty found, it did not find that Mr Duarte Tavares fitness to practice was currently impaired.

144. The Tribunal concluded that a finding of impairment by reason of misconduct was necessary in order to uphold all three limbs of the overarching objective.

145. Accordingly, the Tribunal determined that Mr Duarte Tavares's fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 07/06/2023

146. Having determined that Mr Duarte Tavares' 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 on the appropriate sanction, if any, to impose.

The Evidence

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

Submissions

Submissions on behalf of the GMC

148. On behalf of the GMC, Ms Duckworth submitted that the only appropriate sanction was erasure.

149. Ms Duckworth addressed each of the sanctions in turn. She submitted that as this is a case of serious misconduct, taking no action would be inappropriate and conditions would not be workable. With regard to suspension, Ms Duckworth referred the Tribunal to the Sanctions Guidance ('SG') and submitted that as there have been serious breaches of GMP, no acknowledgement of fault, and no evidence of remediation, suspension was neither sufficient or appropriate. She further submitted that Mr Duarte Tavares has expressly stated that he wished his name to be removed from the Register as he is no longer practising.

150. Ms Duckworth reminded the Tribunal that Mr Duarte Tavares has not demonstrated insight or provided evidence of remediation. Further, she submitted, Mr Duarte Tavares failed to work collaboratively with colleagues, did not arrange for appropriate investigations before undertaking procedures and his inadequate medical records compromised patient safety. His response to the Allegation at the Rule 15 stage she submitted was woefully inadequate. She further submitted that there is no evidence of mitigation except for the lapse of time between the Allegation and now.

151. Ms Duckworth reminded the Tribunal that they have found that the poor decision making and poor surgical technique placed both patients at risk of harm. The surgery undertaken on patient A could have resulted in injury to the brain. The operation on Patient B could have caused the cancer to spread to healthy tissue, and that had driven the Tribunal to the conclusion that the conduct fell so far short of the standards reasonably to be expected as to amount to serious misconduct.

152. Ms Duckworth further submitted that the Tribunal have found that Mr Duarte Tavares acted dishonestly when he completed a referral letter for Patient B which contained misleading statements and omitted relevant information. Instead of prioritising patient safety by providing full, complete and honest information, the doctor had tried to cover up his poor clinical performance and decision making.

153. Ms Duckworth submitted that Mr Duarte Tavares' only acknowledgement of wrongdoing had been during the Care UK investigation when he accepted that with the benefit of hindsight that he should have used FNA on Patient B. In his correspondence with the GMC about the allegations, Mr Duarte Tavares denied the Allegations and sought to explain and justify his actions.

154. With regard to erasure, Ms Duckworth referred the Tribunal to paragraphs 108 and 109 of the SG, below. She submitted that patient safety was engaged because Mr Duarte Tavares had put his own interests before his patient. She also submitted that his persistent failures jeopardised public confidence in doctors and were not consistent with maintaining professional standards in the profession.

155. Ms Duckworth finally submitted erasure was proportionate and the only appropriate sanction in this case.

The Tribunal's Approach

156. The decision as to the appropriate sanction, if any, to impose in this case is a matter for the Tribunal exercising its own judgement. In reaching its decision, the Tribunal has taken the SG into account, the principles of GMP, and borne in mind the over-arching objective. The Tribunal has considered each sanction in ascending order of seriousness, starting with the least restrictive.

157. The Tribunal has given consideration to its findings of misconduct and impaired fitness to practise as well as to the submissions made by Ms Duckworth on behalf of the GMC.

158. Throughout its deliberations the Tribunal bore in mind that although sanctions are not intended to be punitive, and exist to protect patients and maintain public confidence, they may have a punitive effect. In making its decision, the Tribunal also had regard to the principle of proportionality, and took account of Mr Duarte Tavares' interests as well as those of the public. The Tribunal also identified, considered and balanced the mitigating and aggravating factors.

The Tribunal's Determination on Sanction

Aggravating and Mitigating Factors

159. The Tribunal has already set out its decision on the facts and impairment which it took into account during its deliberations on sanction. Before considering what action, if any, to take in respect

of Mr Duarte Tavares' registration, the Tribunal considered and balanced any aggravating and mitigating factors in this case.

160. The Tribunal identified the following aggravating factors:

- Mr Duarte Tavares has not taken responsibility for his actions and/or apologised but in respect of his clinical conduct, attributed some responsibility to a patient;
- Mr Duarte Tavares' actions could potentially have put Patient A and Patient B at risk of harm;
- There is no evidence that Mr Duarte Tavares' has developed any insight into his misconduct;
- In spite of the period of time that has elapsed since these events Mr Duarte Tavares has not produced any evidence of reflection or remediation;
- Mr Duarte Tavares acted dishonestly in relation to the referral letter, his dishonesty related to his deficient professional performance and care, and then he maintained that dishonest account during investigations with Care UK and his regulator.

161. The Tribunal did not accept the submission that the lapse of time since the index events amounted to a mitigating factor as Mr Duarte Tavares was suspended by Care UK and then resigned.

162. The Tribunal did, however, consider that his limited acceptance that he should have performed a FNA on Patient B was a mitigating factor. Although there was limited evidence about it, the Tribunal also took account of the evidence that at the time of the index events, Mr Duarte Tavares' wife was ill and he was travelling to Portugal to support her. The Tribunal noted the suggestion by Dr E that Mr Duarte Tavares performance was initially acceptable but declined over time.

No action

163. The Tribunal first considered whether to conclude the case by taking no action. It noted that taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances. The Tribunal determined that there were no exceptional circumstances in this case and that, given the seriousness of its findings, it would not be sufficient, proportionate, or in the public interest to conclude this case by taking no action.

Conditions

164. The Tribunal has had regard to the following paragraphs of the SG:

> *81 Conditions might be most appropriate in cases:*
>
> *b involving issues around the doctor's performance*
> *c where there is evidence of shortcomings in a specific area or areas of the doctor's practice*
> *…*
>
> *82 Conditions are likely to be workable where:*
>
> *a the doctor has insight*

b *a period of retraining and/or supervision is likely to be the most appropriate way of addressing any findings*

c *the tribunal is satisfied the doctor will comply with them*

d *the doctor has the potential to respond positively to remediation, or retraining, or to their work being supervised.*

84 Depending on the type of case (eg health, language, performance or misconduct), some or all of the following factors being present (this list is not exhaustive) would indicate that conditions may be appropriate:

165. The Tribunal next considered whether it would be sufficient to impose conditions on Mr Duarte Tavares' registration. The Tribunal noted that conditions are appropriate, measurable and workable in certain circumstances including where a doctor has been open and honest and has shown insight. It also noted that conditions may be appropriate where a Tribunal is satisfied that the doctor will comply with them and has the potential to respond positively to their work being supervised.

166. The Tribunal noted that the SG provides that in cases of dishonesty, it is difficult to identify any conditions that could be appropriate, proportionate, workable, and measurable. Mr Duarte Tavares' misconduct, failure to acknowledge his misconduct, and failure to cooperate during the investigation with his regulator, led the Tribunal to determine that it was not possible to formulate appropriate and workable conditions and were not confident in any event that he would comply with any conditions.

167. The Tribunal was also of the view that imposing conditions on Mr Duarte Tavares' registration would not sufficiently mark the seriousness of his dishonest conduct.

Suspension

168. The Tribunal went on to consider whether to impose a period of suspension on Mr Duarte Tavares' registration. The Tribunal accepted that suspension does have a deterrent effect and could be used to send a signal to Mr Duarte Tavares, the profession, and the public about what is regarded as behaviour unbefitting a registered doctor. It also acknowledged that suspension is an appropriate response to misconduct which is sufficiently serious that action is required in order to protect members of the public and maintain public confidence in the profession but falls short of being fundamentally incompatible with continued registration. The Tribunal also noted the SG provides that suspension may be appropriate where there is an acknowledgement of fault, and it is satisfied the conduct will not be repeated.

169. The Tribunal therefore considered whether it should impose a period of suspension on Mr Duarte Tavares' registration and had regard in particular paragraphs 91, 92, 93, 94 and 97a, b, e, f and g of the SG:

91 Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.

92 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).

93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions (see paragraphs 24–49).

94 Suspension is also likely to be appropriate in a case of deficient performance or lack of knowledge of English in which the doctor currently poses a risk of harm to patients but where there is evidence that they have gained insight into the deficiencies and have the potential to remediate if prepared to undergo a rehabilitation or retraining programme.

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

a A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.
…

b In cases involving deficient performance where there is a risk to patient safety if the doctor's registration is not suspended and where the doctor demonstrates potential for remediation or retraining.

…

e No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.

f No evidence of repetition of similar behaviour since incident.

g The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.'

170. As outlined in its determination on impairment, the Tribunal considered that Mr Duarte Tavares' misconduct constituted serious breaches of GMP which included dishonesty, a breach of one of the fundamental tenets of the medical profession. The Tribunal acknowledged that Mr Duarte

Tavares has had a longstanding career. The Tribunal heard no evidence of any previous findings against him. However, the Tribunal concluded that evidence of dishonesty associated with clinical care, failure to evidence insight and remediation, failure to fully engage with the GMC and the various breaches of GMP identified in the Stage 1 and 2 Determinations, suggested that suspension was not an adequate or proportionate sanction. The Tribunal concluded that the aggravating features of this case were so significant, and the gravity of Mr Duarte Tavares' misconduct such that it is fundamentally incompatible with continued registration.

171. Accordingly, the Tribunal determined that suspension would not be sufficient or proportionate to promote and maintain public confidence in the medical profession or uphold proper professional standards for members of the profession.

Erasure

172. As a result of its conclusions above, the Tribunal determined that the only appropriate sanction in this case is erasure. The Tribunal reminded itself of the aggravating factors it had identified in this case and noted the following paragraphs of the SG were relevant to its deliberations:

> **'**108 *Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.*
>
> '109 *Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).*
>
> a *A particularly serious departure from the principles set out in Good medical practice where the behaviour is fundamentally incompatible with being a doctor.*
>
> b *A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety*
>
> …
>
> d *Abuse of position/trust (see Good medical practice, paragraph 65: 'You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession').*
>
> …
>
> h *Dishonesty, especially where persistent and/or covered up (see guidance below at paragraphs 120–128).*

i *Putting their own interests before those of their patients*

…

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

120 Good medical practice states that registered doctors must be honest and trustworthy, and must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession.

125 Examples of dishonesty in professional practice could include:

b falsifying or improperly amending patient records

…

e failing to take reasonable steps to make sure that statements made in formal documents are accurate.

128 Dishonesty, if persistent and/or covered up, is likely to result in erasure

129 Cases in this category are those where a doctor has not acted in a patient's best interests and has failed to provide an adequate level of care, falling well below expected professional standards (set out in domains one and four of Good medical practice on knowledge, skills and performance, and maintaining trust). Particularly where there is a deliberate or reckless disregard for patient safety or a breach of the fundamental duty of doctors to 'Make the care of [your] patients [your] first concern'

132 However, there are some cases where a doctor's failings are irremediable. This is because they are so serious or persistent at, despite steps subsequently taken, action is needed to maintain public confidence. This might include where a doctor knew, or ought to have known, they were causing harm to patients and should have taken steps earlier to prevent this.

173. The Tribunal considered all of the above paragraphs of SG to be engaged in this case. It noted that although its findings in relation to dishonesty related to the referral letter, it involved a number of misleading statements against a backdrop of what Professor C described as '*wholly unreliable*' record keeping. Additionally, the Tribunal reminded itself that Mr Duarte Tavares maintained his dishonest account during the Care UK investigation and to his regulator. Having had regard to this guidance and recalling its findings, the Tribunal found that Mr Duarte Tavares' misconduct and level of dishonesty were incompatible with his continued registration. It considered that Mr Duarte Tavares had put his own interests ahead of his patient's safety and had failed to maintain the necessary clinical standards, which in his case fell considerably short of what is expected of a doctor.

174. The Tribunal considered the current level of Mr Duarte Tavares' insight and was of the view that he had not demonstrated any insight into his misconduct. The Tribunal was concerned that despite Mr Duarte Tavares having had the opportunity, to recognise his misconduct and demonstrate insight in his response to the allegation and his emails to the regulator and the Tribunal, he had not

only maintained denials about how his misconduct and dishonesty had affected Patient A, Patient B and the medical profession overall, but had continued to justify his conduct.

175. Overall, the Tribunal concluded that since the original events in 2018 and 2019, Mr Duarte Tavares has shown a persistent lack of insight into the seriousness of his actions, and it has not been provided with any meaningful evidence of reflection or remediation and consequently there remained a risk of Mr Duarte Tavares repeating his misconduct.

176. Applying the principle of proportionality, the Tribunal was of the view that erasing Mr Duarte Tavares name from the Medical Register is the only appropriate sanction. Only erasure would reflect the gravity of the misconduct, and achieve the objectives of protecting patients and maintaining public confidence in the profession. It would send a clear message to Mr Duarte Tavares, the profession and the public that his misconduct constituted behaviour unbefitting and incompatible with that of a registered doctor.

177. The Tribunal therefore determined that Mr Duarte Tavares's name be erased from the Medical Register.

178. Unless Mr Duarte Tavares exercises his right of appeal, his name will be erased from the Medical Register 28 days from the date on which written notice of this decision is deemed to have been served upon him. A note explaining his right of appeal will be sent to him.

Determination on Immediate Order - 07/06/2023

179. Having determined that Mr Duarte Tavares' name be erased from the medical register the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Mr Duarte Tavares' registration should be subject to an immediate order of suspension.

Submissions

180. Ms Duckworth referred the Tribunal to the relevant paragraphs of the SG. She submitted it is necessary to maintain public confidence in the profession given the serious nature of Mr Duarte Tavares' misconduct and for that reason an immediate order of suspension was required.

The Tribunal's Determination

181. In reaching its decision, the Tribunal took into account the submissions and its previous determinations.

182. The Tribunal exercised its own judgement and took into account the principle of proportionality. The Tribunal bore in mind that it may impose an immediate order where it was satisfied that it was necessary for the protection of members of the public or is otherwise in the public interest or was in the best interests of the practitioner. It has also considered the guidance given in paragraphs 172, 173, and 178 of the SG relating to immediate orders:

> *172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor include avoiding putting them in a position where*

they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.

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

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

183. The Tribunal has found that the nature of Mr Duarte Tavares' misconduct was serious. The Tribunal has determined this was fundamentally incompatible with continued registration and its substantive order upheld the overarching objective in maintaining public confidence in the profession.

184. Having considered the submissions, and in light of all the circumstances of the case and in particular having regard to the gravity of the misconduct, the Tribunal determined that it was proportionate and in the public interest to impose an immediate order of suspension.

185. This means that Mr Duarte Tavares' registration will be suspended from the date on which notification of this decision is deemed to have been served upon him. The substantive direction 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.

186. The interim order is revoked.

187. That concludes this case.

ANNEX A – 30/05/2023

Determination on Service and Proceeding in Absence

188. Mr Duarte Tavares was neither present nor represented at the hearing.

Service

189. The Tribunal was provided with a copy of a Service bundle from the GMC. This included screenshots of the contact information held for Mr Duarte Tavares on the GMC system namely his registered postal address and his email address. Ms Duckworth submitted that notification of the hearing had been served upon Mr Duarte Tavares.

190. The Tribunal was provided with a Notice of Allegation ('NOA') letter sent by the GMC on 18 April 2023 to an email address provided by Mr Duarte Tavares in 2020. Although this is not the email address contained in the register, it is apparent from email correspondence that this is his correct email address. Mr Duarte Tavares had responded to a number of emails using this email address. The Tribunal noted the delivery receipt on the same day and the email acknowledgement from Mr Duarte Tavares on 26 April 2023. In his response email Mr Duarte Tavares stated that he acknowledged receipt of all the documents but did not identify precisely what that included.

191. The Tribunal noted the NOA was also posted to Mr Duarte Tavares' registered address on 20 April 2023. The Tribunal was provided with a screenshot of proof of delivery dated 27 April 2023.

192. The Tribunal was further informed that the MPTS sent a Notice of Hearing ('NoH') dated 20 April 2023 to the same email address provided by Mr Duarte Tavares to the GMC. Mr Duarte Tavares did not respond. Accordingly, the NoH was posted to his registered postal address on the 24 April 2023. The Tribunal was provided with a screenshot of proof of return dated 19 May 2023.

193. The Tribunal noted that there are strict rules in relation to service. Mr Duarte Tavares had not responded to the MPTS NoH email, nor was there a read receipt. Whilst a letter had been sent to his address in Portugal, the Tribunal was concerned that when delivery was checked, the MPTS were informed that an attempt to deliver the letter had been made but was unsuccessful because *'no one was in'.* The letter was not delivered and was returned to the MPTS. There was no evidence before the Tribunal that Mr Duarte Tavares was made aware of the attempted delivery or provided with the opportunity to collect the letter from another location.

194. In light of the this, on day one of the proceedings the LQC requested a further email to be sent to Mr Duarte Tavares asking if he was aware of the hearing. The GMC also sent an email to the doctor to which he responded by email the same day stating:

> *'As stated before I will be not attending.*
> *I am retired and out of the UK. Not working anymore.*
> *Yours sincerely,*
> *Jose Tavares '*

195. The Tribunal noted that the email from which Mr Duarte Tavares' response came was the same email address in respect of which all other email correspondence had been sent and received. The Tribunal was therefore satisfied that Mr Duarte Tavares' email acknowledging receipt of the documentation included the NoH letter. The Tribunal referred to Schedule 4 para 8 of the Medical Act 1983 which reads,

> *'6)For the purposes of this paragraph, service of a notice sent by email is effected only if there is an electronic receipt showing that the email has been opened (or if the recipient acknowledges receipt in some other way)'.*

196. The Tribunal therefore concluded Mr Duarte Tavares had received service of the NoH letter. The Tribunal further determined that, in any event, all reasonable efforts to serve the NoH have been satisfied in accordance with the Rule 40.

Proceeding in Absence

197. In considering whether to proceed in Mr Duarte Tavares absence, the Tribunal had regard to Rule 31 of the Rules:

> '31. *Where the practitioner is neither present nor represented at a hearing, the Committee or Tribunal may nevertheless proceed to consider and determine the allegation if they are satisfied that all reasonable efforts have been made to serve the practitioner with notice of the hearing in accordance with these Rules.*'

198. The Tribunal then went on to consider whether it would be appropriate to proceed with this hearing in Mr Duarte Tavares' absence pursuant to Rule 31 of the Rules. The Tribunal was conscious that the discretion to proceed in the absence of the doctor should be exercised with caution, balancing the interests of the doctor with the wider public interest.

199. Ms Duckworth invited the Tribunal to infer that Mr Duarte Tavares had voluntarily waived his right to attend, citing *R v Jones* [2002] C App R 9. Ms Duckworth also referred to the case of *GMC v Adeogba and Visvadis [2016] EWCA Civ 162*. Ms Duckworth invited the Tribunal to proceed with the hearing in Mr Duarte Tavares' absence.

200. Ms Duckworth submitted that Mr Duarte Tavares was aware of the hearing. Further, Ms Duckworth referred the Tribunal to previous email correspondence in the main bundle in which Mr Duarte Tavares expressed that he will not be attending and that he is not practicing anymore. She submitted that he has acknowledged receipt of the materials to be relied upon and has made it plain that he had no intention of appearing. Ms Duckworth submitted that not only had Mr Duarte Tavares not requested an adjournment, but his view expressed in an email in March 2023 was that the postponement of the matter was having an adverse impact upon him. She further submitted that there has been no indication that Mr Duarte Tavares wishes to be legally represented or that he was unable to instruct a legal representative of his choice.

201. Ms Duckworth submitted that more than reasonable efforts had been made to contact Mr Duarte Tavares. Ms Duckworth submitted that there is no indication that if the hearing was

adjourned, Mr Duarte Tavares would attend any future hearing. She also submitted that, given the concerns in this case, it is in the public interest to proceed with the hearing today.

202. In deciding whether to proceed with this hearing in Mr Duarte Tavares' absence, the Tribunal carefully considered all the information before it.

203. The Tribunal was satisfied that all reasonable efforts had been made to properly serve Mr Duarte Tavares with notice of the hearing and he is aware of these proceedings. There has been no application for an adjournment from Mr Duarte Tavares and there has been no indication that he would attend a hearing on an alternative date or by any alternative means. Additionally, Mr Duarte Tavares has not given any indication that he wishes to be legally represented at the hearing. Given the contents of Mr Duarte Tavares' emails dated 8 February 2023 and 30 May 2023 the Tribunal was satisfied that an adjournment of any length of time was unlikely to result in Mr Duarte Tavares' attendance. The Tribunal concluded he had voluntarily absented himself.

204. The Tribunal concluded it would be in the public interest for this hearing to proceed without further delay and that it would be in the interests of justice to proceed in the absence of Mr Duarte Tavares.