Record of Determinations – Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 27/01/2020 - 21/02/2020
Medical Practitioner’s name: Dr Marco CAPECE

GMC reference number: 7518099
Primary medical qualification: Laurea 2011 Universita degli Studi di Napoli Federico II

Type of case
New - Misconduct

Outcome on impairment
Impaired

Summary of outcome
Suspension, 12 months.

Tribunal:

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<tr>
<th>Legally Qualified Chair</th>
<th>Mr Tim Bradbury</th>
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<td>Lay Tribunal Member:</td>
<td>Ms Elizabeth Daughters</td>
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<td>Medical Tribunal Member:</td>
<td>Dr Noel Bevan</td>
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Tribunal Clerk: Mr John Poole

Attendance and Representation:

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<th>Medical Practitioner:</th>
<th>Present and not represented</th>
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<td>GMC Representative:</td>
<td>Mr Charles Garside, QC</td>
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Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held in public.
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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 - 17/02/2020

Background

1. Dr Capece qualified in 2011 from the University of Naples Federico II, Italy and has subsequently pursued specialist training in Urology. At the time of the events that are the subject of this hearing, he was undertaking a Fellowship at the University College London Hospital (UCLH) in the Andrology Department as part of his specialist training scheme in Italy, which is the equivalent to the specialist register scheme in the UK. Dr Capece completed his training in July 2017 and was appointed as a Specialist Urologist at a hospital in Italy from October 2017 – August 2018. Since April 2019, he has been working as a Research Fellow at the University of Naples Federico II, in the Interdepartmental Centre for Research in Robotic Surgery.

2. In summary, the allegation that has led to Dr Capece’s hearing relates to a vaginectomy procedure carried out on Patient A on 29 October 2019. Dr Capece did not perform the surgery himself but had been delegated to carry out the consent procedure by Mr O who was to perform the procedure. It is alleged that Dr Capece failed to obtain consent for a vaginectomy procedure and that he added the words ‘+vaginectomy’ on to Patient A’s consent form without Patient A’s knowledge and despite Patient A having previously stated he did not want a vaginectomy and despite Dr Capece not having obtained consent for the vaginectomy. It is alleged that Dr Capece, at the time of amending the consent form, knew that Patient A had not consented to the vaginectomy procedure and that Dr Capece’s actions were dishonest.

Patient A

3. Patient A began formal gender transition from at least 2013. He had been attending a Gender Identity Clinic in Belfast from July 2013 following a referral by his GP. Over the next two years he underwent an extended assessment along with supportive psychotherapy. Patient A changed his name by Deed Poll in September 2013 and began his formal real life experience, living as a man, in March 2014, during which time he also started hormone therapy. He underwent reconstructive chest surgery in November 2014 and completed his formal real life experience in March 2015.
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4. Patient A’s case was reviewed and in April 2015, Dr J, Consultant Psychiatrist at the Brackenburn Clinic (of Belfast Health and Social Care Trust), referred Patient A for onward assessment as to his suitability for gender reassignment surgery.

5. In July 2015, Patient A had an appointment with Mr C, Consultant Urologist at SPA. At this appointment the surgical options of either a phalloplasty or metoidioplasty were discussed with Patient A, as summarised in a letter sent by Mr C to Dr J on 21 July 2015. These alternative procedures both result in the construction of a phallus. At that appointment Mr C did not think that metoidioplasty was a good option for Patient A.

6. Following the appointment, Patient A was unsure about which procedure to choose. He later consulted with Dr J and they discussed Mr C’s letter. During this consultation, Patient A made the decision to have a metoidioplasty. On 16 November 2015, Dr J wrote to Mr C confirming that following discussion about the options available, Patient A had decided, after careful consideration, to have a metoidioplasty along with a hysterectomy.

7. Patient A saw Mr B (a consultant Uroandrologist practising with SPA) on 9 December 2015. During the clinic, Mr B and Patient A discussed the consultation that Patient A had with Mr C and the reasons why Patient A had opted for a metoidioplasty rather than a phalloplasty. They discussed that the proposed surgical procedure would consist of three stages, the second of which would include laparoscopic hysterectomy, completion metoidioplasty and ablation vaginectomy. A vaginectomy entails the removal of the vagina. In the context of gender reassignment surgery, it is an elective procedure. It can be performed at any time, either alongside a metoidioplasty/phalloplasty or separately. Once performed, a vaginectomy is irreversible.

8. Patient A was advised by Mr B that he had plenty of time to make a decision as the vaginectomy could be carried out at stage 2 of the surgery and could be discussed again at the next consultation before proceeding with stage 2. Patient A confirmed that he wanted to proceed with stage 1 of the procedure and this was carried out as planned on 9 February 2016 by Mr B at the Hospital of St John & St Elizabeth in London.

9. During a follow up appointment on 24 February 2016, Patient A told the SPA practice nurse that he had decided not to have a vaginectomy at the second stage procedure and this was noted in Patient A’s medical notes.

10. Patient A saw Mr B in clinic again on 11 May 2016 where they discussed the next stage of the procedure which would include hysterectomy and completion of the metoidioplasty, but not a vaginectomy. Mr B advised Patient A that there was a higher rate of urethral fistulae without a vaginectomy but that this could be fixed if it happened. Following the consultation, Mr B wrote a letter to Patient A’s GP on 17 May 2016, which summarised the discussions and again recorded that Patient A did not wish
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to have a vaginectomy. A copy of this letter was retained in Patient A’s medical notes at SPA.

11. In August 2016, arrangements were made for Patient A to undergo the next stage of the surgery on 29 October 2016 at the Highgate hospital. A hospital admission booking form was generated on or about 22 September 2016, this form recorded the proposed procedure as being a “complete metoidioplasty and Lap TAHBSO vaginectomy.”

Patient A’s second stage surgery

12. On the evening of 28 October 2016, Patient A was admitted to Highgate hospital where he was consented for the second stage surgery by Mr O’s assistant, Dr Capece. Patient A states that the consent form he signed had ‘completion metoidioplasty’ written on it but it did not have ‘vaginectomy’ written on it. Further, Patient A states that there was no discussion with regard to a vaginectomy and that this was not a procedure to which he had consented.

13. On the morning of 29 October 2016, Patient A was seen in his room by Dr D, a Consultant Gynaecologist who would be performing the hysterectomy. Dr D obtained consent for the hysterectomy and added the necessary details to Patient A’s consent form. She asked Patient A to sign his initials next to the additions to the consent form filled out the previous evening by Dr Capece. Patient A was then given a white carbon copy (‘the carbon copy’) of the consent form and the top (pink) copy of the form (‘the top copy’) was retained in Patient A’s hospital notes.

14. Later that morning Patient A was taken by the anaesthetic nurse, Ms E, to the operating theatre where, following the ‘Sign In’ procedure, he was given anaesthesia in anticipation of the surgery. Patient A did not meet Mr O at any stage, either before or after the surgery.

15. At a follow-up appointment on 4 November 2016 at SPA, one week after the surgery, Patient A enquired of a nurse what surgery he had received as the discharge note given to him referred to other surgeries that he did not want and had not been consented for: vaginectomy and burial of the clitoris. Patient A knew that he had not had the burial of the clitoris but the nurse confirmed that, from what could be seen at this early stage, it appeared that Patient A had received a vaginectomy. Patient A was distraught and crying. Mr O was informed of Patient A’s concerns the same day.

16. On 13 January 2017, the Brackenburn Clinic wrote to Mr B, Mr C and Mr O at the SPA expressing concern that this was a serious adverse incident and requesting that the matter be investigated.

17. On 20 March 2017, SPA sent a letter of response to the Brackenburn Clinic which expressed deep remorse to Patient A and acknowledged that there was no doubt that
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Patient A did not wish to have the vaginectomy performed. It also stated that the entire medical team intended to carry out the vaginectomy, and completed the correct procedures to obtain informed consent from Patient A. The letter also stated that it was not uncommon for patients to change their minds about the details of the surgery required, especially at Stage 2.

18. In a further letter from SPA on 19 June 2017, SPA stated that Patient A had consented to the vaginectomy being performed at the time of the metoidioplasty and that this was confirmed to him by the anaesthetist at the Sign In procedure which is part of the WHO (World Health Organisation) preoperative process, on the day of the operation. Further, they referred to the top copy form which contained the words ‘+ vaginectomy’, which had been obtained from Highgate hospital. Patient A maintains that he never consented to this procedure and that the word ‘vaginectomy’ was not added in his presence for him to initial. Patient A stated that these words were added without his knowledge or consent and he was subsequently able to produce the carbon copy that he had been given and which did not contain the words ‘+ vaginectomy’.

19. Patient A has not had any further surgery since 29 October 2016. Patient A has described that this unwanted surgery has had a profound impact in all aspects of his life including his mental well-being. The GMC’s case is that the reality of Patient A’s behaviour is entirely consistent with someone who had not agreed to have a vaginectomy.

20. The GMC does not allege that Dr Capece caused a vaginectomy to be performed against Patient A’s wishes deliberately. Rather, the vaginectomy was performed through error, an error which Dr Capece subsequently attempted to conceal by amending the consent form without Patient A’s knowledge or consent.

The Outcome of Applications Made during the Facts Stage

21. The Tribunal granted a GMC application, made pursuant to Rule 34(13) of General Medical Council (Fitness to Practise Rules) 2004 as amended (‘the Rules’), for the GMC’s expert witness, Dr F, to give evidence by means of a video link. The Tribunal’s reasoning is included at Annex A.

The Allegation and the Doctor’s Response

22. The Allegation made against Dr Capece is as follows:

1. On 28 October 2016 you took Patient A’s consent for completion metoidioplasty surgery and you failed to:

   a. review Patient A’s medical records to confirm:

      i. information already given to Patient A; To be determined
ii. details of the proposed procedure; To be determined

b. confirm with Patient A:
   i. the information already given to him; To be determined
   ii. details of the proposed procedure; To be determined

c. inform Patient A of the risks and benefits of a vaginectomy
   To be determined

2. You failed to obtain Patient A’s consent for a vaginectomy.
   To be determined

3. On or around 28 October 2016 you added the word ‘vaginectomy’ on the pink copy of Patient A’s consent form:
   i. without Patient A’s knowledge; To be determined
   ii. despite Patient A having stated that he did not want a vaginectomy; To be determined
   iii. despite not having obtained consent for a vaginectomy.
      To be determined

4. You knew Patient A had not consented to the vaginectomy procedure.
   To be determined

5. Your action outlined in paragraph 3 was dishonest by reason of paragraph 4.
   To be determined

The Facts to be Determined

23. In light of Dr Capece’s response to the Allegation made against him, the Tribunal is required to determine the entirety of the Allegation.

Factual Witness Evidence

24. The Tribunal received evidence on behalf of the GMC from the following witnesses in person:

   - Patient A;
   - Professor C (formerly Mr C), NHS Professor of Urology at UCLH and Medical Director at SPA since 1996;
   - Ms E, Theatre Practitioner/anaesthetist nurse;
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- Mr K, Scrub Practitioner in Squire Harpenden Hospital and at the time of the events, scrub practitioner at Highgate hospital;
- Dr D, Gynaecological Oncologist Consultant in the NHS and also works with the SPA team, where she undertakes hysterectomy procedures;
- Ms L, Loan Equipment and Prosthetic Co-Ordinator at Highgate hospital. At the time of the events she worked as a Healthcare Assistant in the theatre department at Highgate hospital;
- Mr M, Office Manager at SPA where he manages the operating lists and the scheduling of patients for operations;
- Dr N, Clinical Fellow in Andrology at UCLH who also provides surgical assistance at SPA.

25. Dr Capece provided an undated witness statement in advance of the hearing and produced a further witness statement at the hearing on 11 February 2020. He also gave oral evidence to the Tribunal.

26. The Tribunal also received evidence on behalf of Mr O from Dr G, Consultant Anaesthetist at NHS Barts Health. Dr G undertakes private work and at the time of the events, he was the main anaesthetist for SPA at the Highgate hospital.

27. In addition to providing oral evidence to the Tribunal, Dr G provided a witness statement dated 27 June 2019 and various exhibits, as well as a supplemental statement dated 7 February 2020. Dr G’s witness statement was originally taken by the GMC but the GMC subsequently decided not to rely upon his evidence.

28. The Tribunal also received various testimonial letters in support of Dr Capece.

Expert Witness Evidence

29. The Tribunal received evidence from two expert witnesses, Dr F, Consultant Gynaecologist and Mr H, Consultant Urological Surgeon.

Documentary Evidence

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

- Various relevant medical records and letters in relation to Patient A’s medical history and his gender reassignment procedures;
- Copies of the consent forms relevant to the procedures undertaken on 29 October 2016. These consisted of the top copy retained in the Patient A’s hospital notes and the carbon copy which was given to Patient A. On the top copy, the word ‘+ vaginectomy’ was present whereas on the carbon copy (of which the Tribunal was provided with the original), the word ‘+ vaginectomy’ did not appear;
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- Various documents, statements and interview notes relating to SPA’s internal investigation of the incident;
- Good Medical Practice 2013 (GMP);

The Tribunal’s Approach

31. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Capece does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e. whether it is more likely than not that the events occurred. In relation to the standard of proof, the Tribunal was referred to and was mindful of, the Judgment in Re B (children) [2008] EWCA Cib 282.

32. When considering the issue of dishonesty, the Tribunal was mindful of the LQC’s advice that it must:

- Firstly, try to determine, if possible, Dr Capece’s state of mind at the time of the allegedly dishonest actions that is to say his knowledge or belief as to the facts at the relevant time;
- Secondly, whether Dr Capece’s conduct would be regarded as dishonest by the standards of ordinary decent people.

33. The Tribunal also bore in mind that Dr Capece does not have any previous findings made against him by his regulator or any criminal convictions, and to that extent is of good character.

The Tribunal’s Analysis of the Evidence and Findings

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

35. The Tribunal considered two issues to be central to the determination of a number of the allegations in this case. Firstly, whether Patient A had consented to a vaginectomy and secondly, when and what were the circumstances of the words ‘+ vaginectomy’ being entered into the consent form.

Did Patient A consent to a vaginectomy?

36. The Tribunal considered whether Patient A had at some point changed his mind about not having a vaginectomy and had consented to this procedure. It noted that there is a stark conflict in the evidence on this point. The GMC’s case is that Patient A did not at any stage change his mind and that a vaginectomy was not discussed with Patient A by Dr Capece or anyone else, while Patient A was at
Highgate hospital. Dr Capece’s evidence, supported by Mr O, was that following Patient A’s admission to Highgate hospital, he was seen on two occasions by Dr Capece for the purposes of consent, once on the evening of 28 October 2016 and once on the morning of 29 October 2016 and that by 29 October 2016 Patient A had changed his mind and consented to a vaginectomy.

37. Having considered the evidence, the Tribunal was in no doubt that, since 24 February 2016, Patient A did not want a vaginectomy and he had not gone to the hospital on 28 October 2016 with the expectation of having a vaginectomy. Moreover, the Tribunal determined that Patient A did not at any stage thereafter, change his mind and consent to a vaginectomy. Patient A was clear and consistent in his evidence that he did not speak to Dr Capece at any time on the morning of 29 October 2016.

38. The Tribunal found Patient A to be a truthful and accurate witness. The Tribunal considered that Patient A was someone who had been engaged in his treatment, which had been ongoing for a number of years, and who had a clear understanding of its implications. Further, he was able to make concessions where concessions were due.

39. The Tribunal did not accept the suggestion that Patient A may have been revisited on 29 October and discussed and consented to a vaginectomy but had now forgotten that incident.

40. The Tribunal noted that none of those involved in the care of Patient A appeared to have a specific or precise recollection of this particular patient. This is not surprising given that for the members of staff it was, at the time, a routine operation day and there was no particular reason for Patient A’s case to be memorable. Conversely, this was a significant and traumatic event in the life of Patient A and one which he would be unlikely to have forgotten.

41. The Tribunal also noted that there is nothing in the SPA medical records or the Highgate hospital medical records to suggest that Patient A had a change of heart since March 2016 and decided that he wanted a vaginectomy. In particular, there is nothing in the records to suggest that Patient A had spoken to Dr Capece whilst at Highgate hospital regarding a change of mind in relation to the vaginectomy procedure. The medical records are entirely consistent with Patient A’s account.

42. The Tribunal also considered it significant that the first time that there is any record of a suggestion that Dr Capece had revisited Patient A on 29 October 2016 and discussed a vaginectomy with Patient A, was in September 2017, and this was after the SPA had been made aware of Patient A’s carbon copy of the consent form and that it contained no reference to a vaginectomy.
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43. This was notwithstanding the fact that six days after the procedure Mr O was informed by the nurse who undertook the post-surgery follow-up appointment with Patient A, of Patient A’s distress and the complaint that he had undergone a vaginectomy which he had not wanted nor consented to. As a result, Mr O’s evidence was that he had sought unsuccessfully to obtain a copy of the consent form. Shortly thereafter (it is not clear when) he said he had spoken to Dr Capece as to whether he had consented Patient A for a vaginectomy. Dr Capece also maintains that he had spoken to Mr O shortly after the complaint.

44. The Tribunal concluded that it is highly improbable that Mr O and Dr Capece would not have recalled so soon after the procedure, that Dr Capece had revisited Patient A and discussed a vaginectomy and that Patient A had given consent for the procedure.

45. Furthermore, SPA received a complaint from the Brackenburn Clinic in January 2017. The documentation demonstrates that there were discussions involving, either jointly or individually, Mr I (Practice Manager), Mr O, Dr G and Dr Capece in relation to what may have occurred in order to formulate a response to the complaint. This resulted in a letter being sent to the Brackenburn Clinic on 20 March 2017 the content of which Mr O had apparently approved. In this letter the SPA did not make any reference to Dr Capece having revisited Patient A and Patient A changing his mind on this occasion. Further, the letter referred to the author being unable to reconcile the conflict (between the fact that Patient A had not wanted a vaginectomy and the top copy consent form containing the word +vaginectomy). In this letter, Mr I acknowledged that:

‘We are in no doubt that Patient A did not wish to have the vaginectomy performed.’

46. The Tribunal considered that the SPA’s reply demonstrated that following the investigation of the event at this stage, which had included a discussion with Mr O as to what had occurred, no suggestion had been made that anyone had recalled that Patient A had changed his mind.

47. The Tribunal therefore rejected this account principally given by Dr Capece and supported by Mr O and Dr G, as it was only proffered after Patient A’s carbon copy had come to light, almost a year after Patient A’s surgery. It is not recorded prior to this as being anyone’s recollection. The Tribunal considered that the letter demonstrated that SPA was at a loss to explain what had occurred other than to mention that:

‘It is not uncommon for patients to change their minds about the details of the surgery required, especially at “Stage 2” when there can be a daunting number of permutations..’
Mr I also acknowledged that:

‘.. I do not feel that we have completely understood what went wrong..’

48. In fact, despite Dr Capece saying in early statements from October 2017 and thereafter that he revisited Patient A as he was told to check the consent, he resiled from this in the course of his oral evidence and stated that he had no specific recollection and suggested he could not really remember what had happened but believed it must have happened. Further, he did not assert that he had been at the team briefing prior to surgery and only suggested that there must have been a discussion with Mr O at some stage during the morning but not necessarily during the formal team briefing. It was clear from Dr Capece’s oral evidence that he had virtually no recollection of 28 and 29 October 2016 and his recall was based on what he said would have been his usual practice and what he thinks he would have done at the time.

49. Mr O, in his oral evidence continued to maintain that Dr Capece had been present at the team briefing and that he had told Dr Capece to go and see Patient A to ‘double check’ [the consent]. The Tribunal did not accept that this had occurred, it found that Mr O’s account of this conversation was vague and unconvincing and the Tribunal were not persuaded that he had any specific recall of the team briefing or events of that day. Furthermore, the Tribunal concluded that there would have been no reason, on Mr O’s account, for him to tell Dr Capece to double check, and Mr O was unable to provide any satisfactory explanation for why he had done so.

50. With regard to Dr G, the Tribunal found him to be an unconvincing witness and in regard to his evidence, the Tribunal did not consider it reliable. Dr G had made a number of previous statements on different occasions in which he had conveyed the impression that he had a clear recollection of this procedure, in particular, that he had recalled the words +vaginectomy being on the form at the Sign In procedure. It became apparent, during the course of his oral evidence, that in fact, he had no specific recollection of the incident, rather he was relying upon what he believed should have happened, indeed he was to concede that it was possible that it was Ms E who had checked the consent from at the Sign In procedure and that he may not have seen the form at that time.

51. Furthermore, in his statement provided to the GMC in June 2019, he referred to the team briefing and stated everyone stayed in the meeting (which had included Dr Capece) and nobody left part way through’. However, in February 2020, during the course of this hearing, he provided a further statement in which he claimed to recall Dr Capece leaving the briefing at around the end of the briefing to go upstairs. The implication being, in his latter statement, that Dr Capece had gone to see Patient A again to speak to him. In his oral evidence, he was to clarify his February 2020 statement, that he could not recall whether it was the beginning, middle or end of the meeting that Dr Capece left. The Tribunal was concerned at what
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appeared to be an obvious and significant contradiction between the statement
given in June 2019 and the later statement in February 2020. Furthermore, in his
oral evidence, Dr G admitted that he had no clear recollection of Patient A or what
happened in the operating theatre on 29 October 2016.

When and what were the circumstances of the word ‘+vaginectomy’ being entered
into the consent form?

52. Having concluded that Patient A did not consent to a vaginectomy, the
Tribunal next considered what conclusions it could reach, if any, as to the stage and
in what circumstances the consent form had been amended to include
‘+vaginectomy’.

53. The Tribunal considered whether the words ‘+vaginectomy’ were added to
the consent form before the WHO ‘Time Out’ procedure and before Patient A had
been anaesthetised, or at a time during, or after, the Time Out procedure once
Patient A had been anaesthetised. The Tribunal was entirely satisfied that although it
was uncertain precisely when the consent form was amended, it was amended at a
time subsequent to Patient A being anaesthetised. Having concluded that Patient A
did not want a vaginectomy, had not consented to a vaginectomy and had not had
any further discussion with Dr Capece, there would have been no reason for Dr
Capece to amend the form to include vaginectomy before the procedure was
commenced. The Tribunal considered it was improbable that Dr Capece would
allow the surgical team to perform a procedure which he had no reason to believe Patient
A wanted.

54. Furthermore, the Tribunal considered the time available to Dr Capece to
amend the consent form prior to surgery. It is known that Dr D consented Patient A
for a gynaecological procedure sometime between 08:00 and 08:30 on 29 October
2016, following which Dr D separated the white consent form from the pink form.
The Tribunal considered that at that time ‘+vaginectomy’ could not have been
written on the top copy form as it would have been duplicated on the carbon copy.

55. At 08:30 the team briefing began, the record of which shows the surgeons
and rest of the surgical team were present, there was no record of Dr Capece being
present at this team meeting. Although Mr O maintains that Dr Capece was.

56. At around 08:50 Patient A was escorted directly to the operating theatre by
the anaesthetic nurse, Ms E, who also brought hospital notes which would have
included the top copy form. Patient A was signed in by Ms E and the anaesthetist, Dr
G, at around 9am. This meant that there was a very short period of time in which Dr
Capece could have gone to Patient A’s room and discussed any change of mind
about the surgery with Patient A, amended the consent accordingly and informed Mr
O of Patient A’s change of mind.
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57. Further, the Tribunal considered that the amendment could not have happened prior to Patient A being anaesthetised because the Tribunal heard that at the Sign In procedure, Ms E would have confirmed with Patient A the procedure indicated on the consent form. The Tribunal considered Ms E to be an impressive witness in terms of the clarity of her evidence and it was satisfied that she would have acted as she had described. Given Patient A’s adamant wish not to have a vaginectomy, the Tribunal was satisfied that if the word vaginectomy had been mentioned at that time, Patient A would have challenged this.

The Allegation

Paragraph 1

58. Dr Capece attended Highgate hospital on the evening of Friday 28 October 2016 and one reason for this was to consent any of Mr O’s patients who had been admitted prior to their surgery the following day. He took with him the patients’ medical notes from SPA for the Saturday theatre list and consented Patient A. Patient A’s recollection confirmed Dr Capece’s account that he saw Patient A in his room and consented him for completion of the metoidioplasty as was set out in the medical records (but which indicated there was not to be a vaginectomy). A consent form was completed and signed by Patient A for the procedure that he was expecting Mr O to carry out the following day. The Tribunal accepted Patient A’s evidence that he was not consented for a vaginectomy and that there had been no reference to a vaginectomy by either Dr Capece or Patient A on that evening.

59. The Tribunal determined that Dr Capece did consent Patient A appropriately for completion metoidioplasty. There is no evidence to suggest that Dr Capece had not read Patient A’s medical notes and Patient A was under the impression that Dr Capece had read them. In Patient A’s witness statement he stated that when he asked for clarification from Dr Capece in regard to a procedure, ‘I understood it and was happy enough with the explanation.’ Patient A further stated that he asked what a bilateral oophorectomy was, Dr Capece told Patient A that this was the removal of the fallopian tubes and was in the notes. Patient A stated that ‘this gave me reassurance as I knew what was in my notes.’

60. The Tribunal was satisfied that there had been a discussion about the nature of the surgery as indicated in the medical notes. It was also mindful that Patient A had been through a previous operation and a number of consultations up to this point where the various procedures had been explained to him. At this point, the surgery planned was to complete Patient A’s metoidioplasty and Dr Capece’s role was to confirm that the position had not changed from what was set out in the medical notes and to complete the necessary consent form and obtain Patient A’s signature, which he did.

61. Accordingly, the Tribunal found paragraphs 1ai-ii and 1bi-ii not proved.
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62. The Tribunal found paragraph 1c not proved as Dr Capece was not consenting Patient A for a vaginectomy and as such, he had no duty to inform him of the risks and benefits of a vaginectomy.

Paragraph 2

63. The Tribunal considered whether Dr Capece failed to obtain Patient A’s consent for a vaginectomy.

64. The Tribunal was not satisfied that Dr Capece was under a duty to obtain Patient A’s consent for a vaginectomy at any time. Patient A did not want a vaginectomy and it was a procedure that should never have been carried out, therefore there were no circumstances in which he should have sought Patient A’s consent for a vaginectomy and therefore it would be illogical to say he was under an obligation to seek consent for it. The Tribunal was satisfied that Dr Capece was never, at any time on 28 or 29 October 2016, required or instructed by Mr O or anyone else, to consent Patient A for a vaginectomy.

65. The Tribunal therefore found paragraph 2 of the allegation not proved.

Paragraph 3

66. In Dr Capece’s evidence he confirmed that the insertion of ‘+vaginectomy’ on the consent form was in his handwriting.

67. The Tribunal then considered whether Dr Capece added the words ‘+vaginectomy’ on to the consent form with Patient’s A knowledge. By reference to the Tribunal’s findings above, the Tribunal was satisfied that this addition was made without Patient A’s knowledge. The Tribunal therefore found paragraph 3i proved.

68. The Tribunal then considered whether Dr Capece made the addition despite Patient A having stated that he did not want a vaginectomy and despite not having obtained consent for a vaginectomy. The Tribunal has already found that Patient A had stated previously, as set out in the medical records since February 2016, that he unequivocally did not want a vaginectomy and there is no evidence, beyond that of Dr Capece and Mr O, that he had changed his mind. The Tribunal therefore found paragraph 3ii and 3iii proved.

Paragraph 4

69. The Tribunal then considered whether Dr Capece knew Patient A had not consented to the vaginectomy procedure.
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70. There was nothing in the medical notes since 24 February 2016 that would have suggested to Dr Capece that Patient A had been expecting or had consented to a vaginectomy procedure. The Tribunal has already found that in Dr Capece’s discussion with Patient A at Highgate hospital on the evening of 28 October 2016, a vaginectomy was not discussed.

71. The Tribunal therefore considered that Dr Capece must have known that Patient A had not consented to a vaginectomy procedure. The Tribunal considered, as had been submitted by Dr Capece, whether it was possible that there had been a misunderstanding between Patient A and Dr Capece in that either Dr Capece had misunderstood what Patient A wanted or, alternatively, Patient A had not understood what Dr Capece had said to him. The Tribunal did not accept that this was likely for the reasons already given. Patient A had a clear recollection as to the only conversation that he could recall with Dr Capece and the Tribunal was entirely satisfied that had a vaginectomy featured in the conversation at all, Patient A would have recalled and challenged it.

72. The Tribunal was therefore satisfied that Dr Capece knew that Patient A had not consented to the vaginectomy procedure. It was satisfied that Patient A had not changed his mind.

73. The Tribunal therefore found paragraph 4 of the allegation proved.

Paragraph 5

74. In considering whether Dr Capece’s actions were dishonest, the Tribunal considered what motive, if any, he might have had to alter the consent form to include a vaginectomy.

75. The Tribunal considered that there were at least two possible motives:

1- Dr Capece appreciated that the surgical team had performed a vaginectomy which Patient A did not want and had not consented to, alternatively;

2- Dr Capece assumed that he had been in error in that he had failed to properly consent Patient A because he had omitted to discuss a vaginectomy when that was the planned procedure.

76. The Tribunal concluded that the motive was most likely to be one of these explanations but could not determine which of the two was more likely. However, the Tribunal was satisfied that Dr Capece’s deliberate act of adding the words ‘+vaginectomy’ in the knowledge that he had not discussed a vaginectomy with Patient A or obtained his consent to that procedure, was dishonest.
The Tribunal therefore found paragraph 5 proved

The Tribunal’s Overall Determination on the Facts

1. On 28 October 2016 you took Patient A’s consent for completion metoidioplasty surgery and you failed to:

   a. review Patient A’s medical records to confirm:

      i. information already given to Patient A; **Not proved**

      ii. details of the proposed procedure; **Not proved**

   b. confirm with Patient A:

      i. the information already given to him; **Not proved**

      ii. details of the proposed procedure; **Not proved**

   c. inform Patient A of the risks and benefits of a vaginectomy **Not proved**

2. You failed to obtain Patient A’s consent for a vaginectomy. **Not proved**

3. On or around 28 October 2016 you added the word ‘vaginectomy’ on the pink copy of Patient A’s consent form:

   i. without Patient A’s knowledge; **Determined and found proved**

   ii. despite Patient A having stated that he did not want a vaginectomy; **Determined and found proved**

   iii. despite not having obtained consent for a vaginectomy. **Determined and found proved**

4. You knew Patient A had not consented to the vaginectomy procedure. **Determined and found proved**

5. Your action outlined in paragraph 3 was dishonest by reason of paragraph 4. **Determined and found proved**
Determination on Impairment – 19/02/2020

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

The Evidence

2. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition the Tribunal heard further oral evidence from Dr Capece.

Submissions

GMC submissions

3. On behalf of the GMC, Mr Garside submitted that all subparagraphs of the overarching objective are engaged in this case.

4. Mr Garside submitted that both doctors must have been aware of what happened to Patient A within a week of it happening and were alerted to the fact that Patient A was dissatisfied. He submitted that Mr O and Dr Capece must have thought about the events at that stage and they could and should have been frank about what had happened at that point. He submitted that this was a case where a prompt acceptance and apology was needed. Instead, they chose to maintain a false narrative of what occurred and have continued to maintain that false narrative up to date.

5. Mr Garside noted the Tribunal’s finding that Dr Capece dishonestly altered Patient A’s consent form in order to conceal a lack of consent from Patient A. He invited the Tribunal to consider paragraphs 65 and 71 of GMP.

6. Mr Garside noted the positive testimonials produced in support of Dr Capece and that there is no suggestion of a lack of professional skill. However, he submitted that the dishonesty identified in this case undermines public confidence and needs to be marked with serious action.

7. Mr Garside submitted that it was difficult to see how this could not lead to a finding of impairment by reason of misconduct.

Dr Capece’s submissions

8. Dr Capece gave further oral evidence to the Tribunal at this stage.
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9. Dr Capece said that the finding of dishonesty had shocked him but that he had to accept it. He described the events concerning Patient A as a catastrophe that has affected his life for the last few years. He told the Tribunal that every time he speaks to patients, especially when consenting them or when he sees them post-operatively, Patient A’s case comes to his mind.

10. Dr Capece stated that he has completely changed his practice. He stated that ninety percent of his work is now research and the remainder of the time in clinical practice. He said that he is now very thorough when consenting patients and he provides them with a consent form weeks or months in advance of an operation. On the day of an operation, he sits down and talks to the patient about the consent form and asks if anything is unclear.

11. Dr Capece explained that the consent forms are different in Italy and he gave an example of how he had consented a patient recently. Dr Capece stated that he is now ‘obsessed’ with every part of his clinical practice.

12. Dr Capece expressed remorse for what had occurred and said that he hoped the Tribunal’s findings would not ruin his life and career. He said he was not a bad person and does not intend to practise in the UK again. He told the Tribunal he lives in Naples and has a wife and daughter and said that he loves what he does and wants to continue to practise as a doctor.

The Relevant Legal Principles

13. 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 judgment alone.

14. In approaching the decision, the Tribunal was mindful of the two stage process to be adopted: first, whether the facts as found proved amounted to misconduct that was serious, second, whether that misconduct which was serious, could lead to a finding of impairment.

15. The Tribunal must determine whether Dr Capece’s fitness to practise is impaired today, taking into account his conduct at the time of the events and any relevant factors since, including, but not limited to, whether the matters are remediable, have been remedied and any likelihood of repetition.

16. The Tribunal reminded itself that there is no comprehensive or all embracing definition of impairment and it is a matter of judgment. However, it considered the observations of Dame Janet Smith in the 5th Shipman report in which she identified four questions that should be considered in determining whether fitness to practise is impaired:
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a) Has the doctor in the past acted and/or is he liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
b) Has he in the past brought and/or is he liable in the future to bring the medical profession into disrepute; and/or
c) Has he in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession;
d) Has he in the past and/or is he liable in the future to act dishonestly.

The Tribunal’s Determination on Impairment

Misconduct

17. The Tribunal first considered whether the facts found proved amounted to misconduct.

18. The Tribunal had regard to the nature of the dishonesty found proved in this case. The dishonesty occurred in a clinical setting and involved the falsification of a formal document of high importance as it provided evidence of Patient A’s consent to a surgical procedure. The document was deliberately altered to present a false picture of there having been a discussion between Patient A and Dr Capece in regard to consent for the vaginectomy procedure and Patient A had consented to the procedure. The Tribunal considered that the purpose of consent forms is to protect patients and doctors. Further, it considered that Dr Capece’s actions seriously undermined patient trust.

19. The Tribunal found that Dr Capece’s actions breached a fundamental tenet of the profession, namely honesty and integrity. It accepted Mr Garside’s submission and agreed that paragraphs 65 and 71 are relevant in this case:

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

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

a You must take reasonable steps to check the information is correct.

b You must not deliberately leave out relevant information.

20. The Tribunal had no doubt that Dr Capece’s conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct that was serious.
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Impairment

21. The Tribunal, having found that the facts found proved amounted to misconduct, went on to consider whether, as a result of that misconduct, Dr Capece’s fitness to practise is currently impaired.

22. The Tribunal acknowledged that it was a single and isolated incident in Dr Capece’s career and there is no evidence of repetition or that he has otherwise acted dishonestly in the past. It was also willing to accept that when Dr Capece made the amendment to the consent form, regardless of the motivation, it may not have been premeditated and may have been done in a moment of panic. However, he has since maintained the false narrative that he had a discussion with Patient A on the morning of 29 October 2016 and that Patient A had changed his mind and consented to a vaginectomy.

23. The Tribunal acknowledged that Dr Capece had not caused the vaginectomy to be performed. However, the Tribunal considered that it is likely that Dr Capece contributed to the considerable and lasting emotional harm this has had on Patient A. Patient A’s complaint was initially dismissed as a result of the alteration made by Dr Capece. It was only by good fortune that Patient A was able to produce his carbon copy of the consent form which he signed on 28 October 2016 which did not have the words ‘+vaginectomy’ on it and thereby confirmed that Patient A had not signed a consent form with this procedure on it. As a result of the false narrative maintained by Dr Capece, Patient A has never received an apology or admission of surgical error.

24. The Tribunal considered that dishonesty is very difficult to remedy and that Dr Capece has not acknowledged the part that he played in undermining Patient A’s credibility.

25. The Tribunal had regard to the four questions identified by Dame Janet Smith in the 5th Shipman report.

26. The Tribunal considered that although the consent form was altered after Patient A’s surgery was commenced, Dr Capece did put Patient A at harm as a result of his dishonest actions, but it considered that it is unlikely he would do it again in the future in a similar situation. The Tribunal considered that Dr Capece probably bitterly regrets his actions and that these proceedings have had a profound impact upon him. Nevertheless, without full insight into his dishonesty, the Tribunal could not be satisfied that there is no risk of repetition of Dr Capece’s misconduct, however it considered this risk to be low.

27. Further, the Tribunal was in no doubt that Dr Capece’s actions have brought the medical profession into disrepute and that he has breached a fundamental tenet of the medical profession.
28. Despite the risk of repetition being low, the Tribunal concluded that Dr Capece’s misconduct was so serious that a finding of impairment was necessary in order to uphold, promote and maintain public confidence in the medical profession, and promote and maintain proper professional standards and conduct for the members of the profession.

29. The Tribunal has therefore determined that Dr Capece’s fitness to practise is impaired by reason of misconduct.

**Determination on Sanction - 21/02/2020**

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

**The Evidence**

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

**Submissions**

**GMC submissions**

3. On behalf of the GMC, Mr Garside invited the Tribunal to consider the overarching objective and the reason for imposing sanctions. In the course of his submissions he referred the Tribunal to various paragraphs of the Sanctions Guidance (November 2019 edition) ('SG').

4. Mr Garside submitted that on the basis of the Tribunal’s findings at the facts stage and impairment stage, the appropriate sanction in this case was one of erasure. In particular, he drew the Tribunal’s attention to the following paragraphs of the SG which gives examples of when erasure may be the appropriate sanction:

   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).
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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.

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

5. In regard to dishonesty, Mr Garside noted that while it was a single incident, Dr Capece continued to maintain the narrative that he obtained Patient A’s consent for the vaginectomy. Mr Garside invited the Tribunal to consider the various paragraphs under the subheading ‘Considering dishonesty’, in particularly paragraphs 125b and 128:

125 Examples of dishonesty in professional practice could include:

b) falsifying or improperly amending patient records

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

6. Mr Garside submitted that superficially Dr Capece’s evidence at the impairment stage was undoubtedly striking and affecting, however, he is at this hearing through his own fault, and at almost any stage before the hearing it was open to him to apologise and to come here and be penitent. Mr Garside submitted that while the Tribunal found that there is no risk of repetition, the seriousness of the misconduct cannot be dealt with in any way other than erasure.

Dr Capece’s submissions

7. Dr Capece told the Tribunal he was sorry if he gave the impression that he wanted to obstruct the investigation in any way. He said that the Tribunal was probably right and that his recall in evidence was based on his usual practice rather and what he thought he would have done at the time, as opposed to his actual recollection of events. He apologised for this.

8. Dr Capece said the Tribunal’s finding has caused him an internal conflict. He had always considered himself to be an honest person and the finding of dishonesty has created problems in his head which are consuming him. He asked that the Tribunal take into account some mitigating factors, in particular his inexperience working in the UK at the time, the lack of supervision and the lapse of time since the incident occurred. He also asked that the Tribunal take into account the testimonials on his behalf and his previous good character.

9. Dr Capece said he accepted he should have done things differently and has tried to understand everything that has happened. He stated that if he were to be erased, the
research he is working on in Italy might be cancelled or funding withdrawn as he is the only medical doctor involved in that research project. He went onto describe the nature of his research and his hope that it might change the world of prostate biopsy in the future. He said it would be very good for patients and that a lot progress has been made already.

10. Dr Capece stated that he has a wife and a five-month old baby to support and has taken all of his annual leave to be at this hearing. He stated that if he loses his job, he would not blame anyone but himself. He said that research and medicine is the only thing he has ever wanted to do, that he has studied his whole life for this and accepts his current situation is all his own fault.

The Tribunal’s Determination on Sanction

11. The Tribunal took into account all of the submissions, its findings and the documentary evidence adduced during the course of these proceedings.

12. The Tribunal had regard to the advice given by the Legally Qualified Chair which is a matter of record.

13. The decision as to the appropriate sanction is a matter for this Tribunal’s own independent judgment. The sanction must be proportionate and tailored to the specific circumstances of the case. In reaching its decision the Tribunal took into account the SG and the statutory overarching objective, which includes the need to:

   a. Protect, promote and maintain the health, safety and well-being of the public,

   b. Promote and maintain public confidence in the medical profession, and

   c. Promote and maintain proper professional standards and conduct for members of that profession.

14. The Tribunal recognised that the purpose of a sanction is not to be punitive, although it may have a punitive effect. Throughout its deliberations, the Tribunal applied the principle of proportionality, balancing Dr Capece’s interests with the public interest.

Aggravating and Mitigating Factors

15. The Tribunal first considered the aggravating and mitigating factors in Dr Capece’s case.

16. The Tribunal considered the following factors to be aggravating:
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- Dr Capece’s dishonesty was serious professional dishonesty in a clinical environment;
- A lack of insight demonstrated by a failure to admit his wrongdoing and then continuing to maintain a narrative he must have known to be false. However, the Tribunal noted in the course of Dr Capece’s oral submissions that he said he had accepted the Tribunal’s findings and that he was at fault. The Tribunal considered that although this was at a late stage, it was evidence of emerging insight and a willingness to acknowledge and face up to his wrongdoing.

17. The Tribunal identified the following mitigating factors:

- It was a single and isolated incident;
- Dr Capece was a junior fellow (a trainee) at the time;
- Dr Capece was not the operating or assisting surgeon but he had been instructed to consent Patient A which he had done so adequately on 28 October 2016;
- He did not cause the wrong procedure to be performed;
- The lapse of time since the incident occurred and that there has been no repetition and the risk of repetition is low;
- The Tribunal was prepared to accept that the alteration of the consent form was done in a moment of panic rather than premeditated. As the Tribunal noted at the facts stage, it appeared that there were two possible motives for Dr Capece amending Patient A’s consent form. Either he knew a vaginectomy should not have been performed but then discovered that a vaginectomy had been performed and he wished to cover up what had happened. Alternatively, he believed that he had been at fault in the consent process and thought he should have consented the patient for vaginectomy as that was what was written on the theatre list. In terms of culpability, the Tribunal concluded that the former motive would be more serious as he would be seeking to cover up a serious surgical error and the potential for further harm to Patient A would have been foreseeable. The latter motive, although providing no justification for Dr Capece’s actions would be less culpable as in these circumstances, Dr Capece may not have foreseen any potential harm to Patient A.

No Action

18. In deciding what sanction, if any, to impose, the Tribunal reminded itself that it must consider each of the sanctions available, starting with the least restrictive, to establish which is appropriate and proportionate in this case.

19. The Tribunal first considered whether to conclude the case by taking no action.
20. The Tribunal considered that there were no exceptional circumstances in this case which might justify taking no action. Moreover, taking no action would be wholly insufficient to mark the gravity of the case.

**Conditions**

21. The Tribunal then considered whether to impose an order of conditions on Dr Capece’s registration would be appropriate. It decided that there were no conditions it could impose to properly address the dishonesty identified in this case. Moreover, Dr Capece is now practising in Italy and has no intention of returning to the UK so conditions would not be workable. In any event, the Tribunal considered that an order of conditions would be wholly inadequate to address the seriousness of this case.

**Suspension**

22. The Tribunal then considered whether it would be sufficient to impose a period of suspension on Dr Capece’s registration.

23. The Tribunal considered the nature of Dr Capece’s dishonesty. It considered that the dishonesty was a single act of amending the consent form and was not, strictly speaking, ‘covered up’. However, it is significant that having amended the consent form Dr Capece did not admit his wrongdoing despite numerous opportunities to do so either subsequent to Patient A’s complaint, during the investigation or in the course of this hearing, and he has maintained what the Tribunal has found to be a false narrative.

24. The Tribunal considered that in all the circumstances, Dr Capece’s misconduct is not fundamentally incompatible with continued registration due to the mitigating factors identified and listed above. In particular, the Tribunal considered that there is no risk to patient safety and that the risk of Dr Capece repeating his actions is low. The Tribunal has found that Dr Capece now has some insight into his misconduct, has accepted the Tribunal’s findings and acknowledged fault. It was also evident to the Tribunal that the whole episode including these proceedings has had a profound impact on Dr Capece and his expressions of remorse appear genuine.

25. The Tribunal had regard to Dr Capece’s testimonials and acknowledged that there is a public interest in good doctors returning to safe practice.

26. The Tribunal considered the factors given at paragraph 109 of the SG which give examples when erasure might be appropriate. It accepted that the factors listed at paragraph 109a, b and h are relevant to this case. In relation to 109h, the Tribunal did not consider the dishonesty to be persistent and/or covered up for the reasons given above. The Tribunal noted that the SG does not indicate that erasure
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must follow if any of the factors listed are present, rather than it may follow. In light of all the mitigating factors in this case, the Tribunal decided that erasure was not necessary to maintain public confidence in the medical profession, and promote and maintain proper professional standards and conduct for members of that profession.

27. The Tribunal determined that the public interest would be sufficiently upheld by a sanction of suspension. Nevertheless, given the serious nature of the case, it found that the maximum period of 12 months suspension was necessary in order to promote and maintain public confidence in the medical profession, and promote and maintain proper professional standards and conduct for members of that profession.

28. The Tribunal considered that it was not necessary to direct a review of Dr Capece’s case. The Tribunal noted that there are no clinical concerns in this case and that dishonesty is difficult to remediate. As such, the Tribunal determined that a review hearing would not serve any useful purpose. Moreover, Dr Capece is currently practising in Italy where his family lives and he has indicated that he has no intention of returning to work in the UK. He has only ever worked in the UK as part of his training programme and has never practised permanently here.

Determination on Immediate Order - 21/02/2020

1. Having determined to suspend Dr Capece for a period of 12 months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Capece’s registration should be subject to an immediate order.

Submissions

2. On behalf of the GMC, Mr Garside submitted an immediate order was necessary and drew the Tribunal’s attention to paragraphs 172 and 178 of the SG which provide that:

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

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.

3. Mr Garside submitted that, in the light of a finding of dishonesty in a clinical context, an immediate order of suspension was necessary in order to uphold public confidence.

4. Dr Capece stated that he is not working in this country and has no intention to come here to work for the rest of his life. He said he did not know what the impact the Tribunal’s sanction will have when he tells his regulator in Italy but that he thinks it would be better not to have an immediate order as well. He stated however, that it was a decision for the Tribunal and thanked the Tribunal for its finding that he was not a risk to patient safety.

The Tribunal’s Determination

5. The Tribunal had regard to paragraphs 172 and 178 of the SG and took account the submissions made by both parties.

6. The Tribunal has found that there is no risk to patient safety and has determined to suspend Dr Capece’s registration on public interest grounds alone. It was satisfied that the substantive order is sufficient to uphold the overarching objective in maintaining public confidence in the profession and that an immediate order would be unnecessarily punitive.

7. This means that Dr Capece’s registration will be suspended 28 days from when notice of this decision is deemed to have been served upon him, unless he lodges an appeal. If Dr Capece does lodge an appeal he will remain free to practise unrestricted until the outcome of any appeal is known.

8. There is no interim order to revoke.

9. That concludes the case.

Confirmed
Date 21 February 2020

Mr Tim Bradbury, Chair
Application for the GMC expert witness to give evidence via video link

1. Mr Garside made an application for the GMC’s expert witness, Dr F, to give evidence to the Tribunal by means of a video link. Mr Garside explained that due to personal circumstances outlined to the Tribunal, Dr F had requested to give evidence by this means, rather than attend the hearing in person.

2. On behalf of Mr O, Mr Forde did not object, under the circumstances, to Dr F giving evidence by means of a video link. Dr Capece did not object to the application either.

3. The Tribunal had regard to the reasons given for why it would be difficult for Dr F to attend the hearing in person as well as the distance he would have to travel. It therefore determined that in the circumstances, and there being no objection or risk of injustice to either Mr O or Dr Capece, it was appropriate and fair to allow the GMC’s application in accordance with Rule 34(13) and (14) of the Rules.