PUBLIC RECORD

**Dates**: 13/09/2021 – 24/09/2021; 07/01/2022; 19/01/2022; 17/02/2022 – 18/02/2022; 21 – 22/09/2022

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| **Medical Practitioner's name:** | Dr Haitham ALSHAFEY |
| **GMC reference number:** | 6080315 |
| **Primary medical qualification:** | MB BCh 2002 Menoufia University |

| 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:**

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| Legally Qualified Chair | Mr Andrew Lewis |
| Lay Tribunal Member: | Ms Liz Daughters |
| Medical Tribunal Member: | Dr Joanne Topping |

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| Tribunal Clerk: | Ms Evelyn Kramer (13 – 24/09/2022; 07/01/2022; 19/01/2022; 21 – 22/09/2022)<br>Ms Rebecca Paterson (17 – 18/02/2022) |

**Attendance and Representation:**

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| Medical Practitioner: | Present and represented (13/09/2021 – 24/09/2021 & 07/01/2022)<br>Not present or represented (17 – 18/02/2022) and (21 – 22/09/2022) |
| Medical Practitioner's Representative: | Mr Jonathan Holl-Allen KC, instructed by Adkirk Law |
| GMC Representative: | Ms Harriet Tighe, Counsel |

## Attendance of Press / Public

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

## Overarching Objective

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

## Determination on Facts - 24/09/2021

1. At various points during the first stage of the hearing, the Tribunal went into private session to hear particular matters in respect of Patient A's health.

## Background

2. Dr Alshafey qualified from Menoufia University in Egypt in 2002 and prior to the events which are the subject of the hearing Dr Alshafey held posts in various specialties in Egypt as the equivalent of a house officer. He began working in the United Kingdom in February 2004 as a Senior House Officer ('SHO') in obstetrics and gynaecology at various hospitals in London and the West Midlands. In 2009, Dr Alshafey took up a full-time private position in 'gynaecological abdominal, vaginal and laparoscopic' surgery for one year before he returned to working as a staff grade doctor on a maternity ward for one year. Dr Alshafey then worked as a locum registrar in obstetrics and gynaecology for three years mainly in Chichester and Worthing. In 2015, Dr Alshafey set up his own practice, Look Younger Clinic ('the Clinic'), which is where he was working at the time of events, the Clinic primarily provided liposuction procedures.

3. The Allegation that has led to Dr Alshafey's hearing can be summarised as failures in relation to obtaining adequate training before carrying out an abdominoplasty and failing to provide adequate care to two patients:

Patient A

4. In relation to his preoperative care of Patient A, it is alleged that Dr Alshafey failed to conduct an adequate physical examination of Patient A, did not discuss the patient's concerns and history nor the proposed procedure and treatment options, and did not record his preoperative consultations or postoperative instructions. It is alleged that Dr Alshafey did not have adequate training to perform an abdominoplasty procedure and that, in doing so, he put Patient A at risk of serious harm and life threatening consequences. It is also alleged that the premises where he carried out the procedure were not safe. Regarding Dr Alshafey's

postoperative care of Patient A, it is alleged that various failures resulted in a risk of severe harm, significant morbidity, and life threatening changes to Patient A. Alternatively, it is alleged that Dr Alshafey failed to keep adequate records of the work he undertook.

Liposuction Procedure

5. Regarding a liposuction procedure on a patient on 13 June 2019, it is alleged that Dr Alshafey did not have up to date qualifications in life support, nor did he have in place appropriate policies or appropriately trained staff. It is further alleged that Dr Alshafey failed to take an adequate history, provide good clinical care, and notify the patient's General Practitioner about the procedure. It is also alleged that the premises where he carried out the procedure were not safe. By reason of his failures, it is alleged that Dr Alshafey put the patient at risk of harm. In the alternative, it is alleged that Dr Alshafey failed to record the patient's allergies and his communication with the patient's General Practitioner.

6. The initial concerns were raised with the GMC by Dr Alshafey who self-referred on 19 January 2019.

## The Outcome of Applications Made during the Facts Stage

7. At the outset of proceedings, the Tribunal received two applications to amend the Allegation, one on behalf of the GMC and one on behalf of Dr Alshafey. The Tribunal granted the GMC's application, made pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to amend paragraphs 1.a. and 4.d. of the Allegation. The Tribunal refused the application made on behalf of Dr Alshafey pursuant to Rule 17(6) of the Rules to delete paragraphs 2.b., 3.b., and 6.b. of the Allegation. The Tribunal's full decision on both applications is included at Annex A.

8. The Tribunal refused the application made on behalf of the GMC pursuant to Rule 34(1) of the Rules to admit Patient A witness statement into evidence as hearsay evidence following Patient A's decision not to attend. The Tribunal's full decision on the application is included at Annex B.

9. On day four of the hearing, following an earlier query from the Tribunal about the wording of paragraph 6.a.i. of the Allegation, the GMC made an application to amend paragraph 6.a.i. pursuant to Rule 17(6) of the Rules. Ms Tighe, Counsel, on behalf of the GMC, submitted that in line with the expert evidence received, it was appropriate to add 'intermediate or advanced' before 'life support' in paragraph 6.a.i.. Ms Tighe submitted that the amendment did not amount to a material change and was instead a clarification to assist the Tribunal in reaching a decision that could be made without injustice. On behalf of Dr Alshafey, Mr Holl-Allen KC disagreed that the amendment did not amount to a material change, but accepted that Dr Alshafey has been aware of the GMC's case that he did not hold an up to date qualification in intermediate or advanced life support. On that basis, the application was not opposed.

10. The Tribunal accepted Mr Holl-Allen's submission that the amendment to paragraph 6.a.i. did amount to a material change to the Allegation. However, it was satisfied that Dr Alshafey had appropriate notice of the evidence the GMC relied on for paragraph 6.a.i.. As this application was agreed, and Dr Alshafey had appropriate notice of the GMC's case, the Tribunal was satisfied that the amendment could be made without injustice. The Tribunal therefore granted the GMC's second application to amend the Allegation under Rule 17(6).

11. The Tribunal refused the application made on behalf of Dr Alshafey, to allow Mr Holl-Allen, to conduct oral evidence in chief, under Rule 34(9) and 34(11) of the Rules. The Tribunal's full decision on the application is included at Annex C.

## The Allegation and the Doctor's Response

12. The Allegation made against Dr Alshafey is as follows:

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

Patient A

1. On 5 November 2018 and 11 December 2018 you conducted preoperative consultations with Patient A and you failed to:

    a. conduct an adequate physical examination of Patient A on 5 November 2018 in that you did not measure and/or assess:
    **Amended under Rule 17(6)**

        i. height; **Admitted and found proved**

        ii. weight; **Admitted and found proved**

        iii. the presence of any abdominal scars; **To be determined**

        iv. the amount of skin excess; **To be determined**

        v. skin laxity; **To be determined**

        vi. the amount of subcutaneous fat; **To be determined**

        vii. abdominal muscle tone; **Admitted and found proved**

        viii. the presence of any divarication; **Admitted and found proved**

        ix. the amount of intra-abdominal fat; **To be determined**

    b. discuss with Patient A:

        i. presenting concerns; **To be determined**

ii. past medical history; To be determined

iii. examination; To be determined

iv. treatment options; To be determined

v. the procedure proposed; To be determined

vi. potential:

i. side effects; To be determined

ii. risks; To be determined

iii. complications; To be determined

vii. obstetric history; To be determined

viii. abdominal operations; To be determined

ix. weight changes. To be determined

2. On 5 January 2019 you performed an abdominoplasty combined with liposuction and fat grafts on Patient A ('the Procedure') and:

a. you failed to:

i. undertake adequate training prior to completing the abdominoplasty procedure; Admitted and found proved

ii. adequately record who administered the local anaesthetic to Patient A; To be determined

iii. perform the:

i. World Health Organisation ('WHO') checklist; Admitted and found proved

ii. veno-thrombo embolism assessment; Admitted and found proved

iv. ensure:

i. you had supervision from an appropriately trained and accredited surgeon whilst performing the Procedure; To be determined

ii. that the premises in which you performed the Procedure were safe; To be determined

b. by not having the adequate training in performing the abdominoplasty procedure you put Patient A at risk of:

i. serious harm; To be determined

ii. life threatening consequences. To be determined

3. On 15 January 2019 you consulted with Patient A and you failed to provide adequate postoperative care, in that you:

a. failed to:

i. detect:

i. skin necrosis; To be determined

ii. impending necrosis; To be determined

ii. measure Patient A's temperature; Admitted and found proved

iii. ensure that the results of Patient A's microbiology were identified; Admitted and found proved

iv. establish the cause of Patient A's infection; To be determined

v. recognise the potential risk of Patient A's infection developing into necrotising fasciitis; To be determined

vi. prescribe appropriate antibiotics; To be determined

vii. arrange for Patient A's urgent admission to hospital for:

i. close observation; Admitted and found proved

ii. exploration of the wound; Admitted and found proved

iii. debridement of the wound; Admitted and found proved

viii. arrange for a further review within 48 hours to confirm that Patient A's infection was not worsening; To be determined

b. put Patient A at risk of the following by failing to undertake the actions as set out at paragraph 3.a.:

i. severe harm; To be determined

ii. significant morbidity; To be determined

iii. life threatening changes. To be determined

4. In the alternative to paragraphs 1-3 above you failed to record having undertaken the actions as outlined at paragraph:

   a. 1.a.; To be determined

   b. 1.b.; To be determined

   c. 2.a.iii.; To be determined

   d. ~~2.a.iv.2.~~ 2.a.iv.1.; To be determined
   Amended under Rule 17(6)

   e. 3.a.. To be determined

5. You failed to record any postoperative instructions. To be determined

Liposuction Procedure

6. On 13 June 2019 you performed liposuction on a patient ('the Liposuction Procedure') and you:

   a. failed to:

      i. hold an up to date qualification in intermediate or advanced life support; To be determined
      Amended under Rule 17(6)

      ii. have a sepsis policy in place; Admitted and found proved

      iii. ascertain preoperatively if the patient had any known allergies; To be determined

      iv. perform:

         i. the WHO 'Five Steps to Safer Surgery' checklist preoperatively and / or postoperatively; Admitted and found proved

         ii. a swab count during and / or at the end of the Liposuction Procedure; Admitted and found proved

      v. monitor both intraoperatively and / or postoperatively the:

i. pulse rate; Admitted and found proved

ii. blood pressure; Admitted and found proved

vi. ensure that the:

i. staff assisting with the Liposuction Procedure were trained operating assistants who could identify basic clinical signs; To be determined

ii. patient was not left unattended during the Liposuction Procedure; To be determined

iii. premises in which you performed the Liposuction Procedure were safe; To be determined

iv. documentation and / or prescriptions for the medications provided to the patient was adequate, including details of analgesia given before, during and after the procedure; Admitted and found proved

vii. notify the patient's General Practitioner about the Liposuction Procedure undertaken; To be determined

b. put the patient at risk of:

i. an allergic reaction by failing to undertake the action set out at paragraph 6.a.iii.; To be determined

ii. potentially dangerous drug interactions by failing to undertake the action set out at paragraph 6.a.iii.; To be determined

iii. unwanted side effects by failing to undertake the action set out at paragraph 6.a.iii.; To be determined

iv. serious harm by failing to undertake the action set out at paragraphs 6.a.iii.-6.a.v.ii.; To be determined

v. tachycardia by failing to undertake the action set out at paragraph 6.vi.ii.; To be determined

vi. lignocaine toxicity by failing to undertake the action set out at paragraph 6.vi.ii.; To be determined

vii. syncope by failing to undertake the action set out at paragraph 6.vi.ii.. To be determined

7. In the alternative to paragraph 6.a.iii.to 6.a.vii. you failed to record having undertaken the actions as outlined at paragraph:

    a. 6.a.iii.; Admitted and found proved

    b. 6.a.iv.; To be determined

    c. 6.a.v.; To be determined

    d. 6.a.vii.. To be determined

## The Admitted Facts

13. Through his counsel, Mr Holl-Allen, Dr Alshafey made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

## The Facts to be Determined

14. In light of Dr Alshafey's response to the Allegation made against him, the Tribunal is required to determine the paragraphs and sub-paragraphs remaining.

## Factual Witness Evidence

15. The Tribunal received oral evidence on behalf of the GMC from Ms B Care Quality Commission (CQC) Inspector. Her witness statement was dated 2 September 2019.

16. Ms B was the lead inspector of the CQC inspection of Dr Alshafey's premises on 13 June 2019. Having heard submissions from counsel the Tribunal approached her evidence upon the following agreed basis: 'Ms B is not an independent expert witness instructed by the GMC in these proceedings to express an opinion on whether the practitioner has fallen short of the standards to be expected of him as a registered medical practitioner, and if so to what extent. Her status in these proceedings is that of a witness of fact. However, she is a CQC Inspector and has professional experience and expertise in that role. As such she was entitled to make statements of opinion reasonably related to facts within her knowledge, and relevant comments based on her own experience, and such statements and comments are admissible in these proceedings: see Multiplex Construction (UK) Limited v Cleveland Bridge Limited [2008] EWHC 2220 (TCC) per Jackson J at 672.'

17. Dr Alshafey provided his own witness statement, dated 1 September 2021 and also gave oral evidence at the hearing.

## Expert Witness Evidence

18. The Tribunal received evidence from two expert witnesses. Mr C, a retired Consultant Plastic Surgeon instructed by the GMC and Mr D, a Consultant Plastic, Burns and Reconstructive Surgeon instructed by Dr Alshafey. Both experts produced individual reports as well as an agreed joint report.

19. Mr C provided his initial expert report on 8 December 2019. He then produced a supplementary report, dated 9 July 2020. Mr C produced a further supplemental report, dated 13 August 2021. Mr C also gave oral evidence at the hearing.

20. The Tribunal was satisfied that it could rely on Mr C's evidence. It found him to be a highly qualified expert, who was fair to Dr Alshafey. He demonstrated a willingness to change his opinion when shown new evidence, either documentary or from Dr Alshafey's own account. He demonstrated this with regard to the question whether Patient A had contracted necrotising fasciitis ('NF') and whether or not Dr Alshafey had written a postoperative plan for Patient A. Mr C was careful not to blame Dr Alshafey for matters on which there was insufficient evidence, did not give evidence outside of his expertise and also highlighted the areas where Dr Alshafey's actions and care were acceptable.

21. Mr D produced an expert report dated 15 June 2021, dealing with the issue of whether Patient A had developed necrotising fasciitis.

22. Following a telephone conference on 4 August 2021, the joint report of Mr C and Mr D was produced. There was broad agreement between both experts. Accordingly, Mr D was not called to give oral evidence on behalf of Dr Alshafey.

## Documentary Evidence

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

- CQC Report, following the inspection carried out on 13 June 2019;
- Correspondence between Dr Alshafey and Patient A, various dates, including consultation letters sent to Patient A, dated 5 November 2018 and 11 December 2018;
- Patient A's selected medical records, and relevant photographs taken preoperatively, intra-operatively and postoperatively;
- A testimonial from the liposuction patient whose procedure took place during the CQC inspection on 13 June 2019, dated 10 July 2019.

## The Tribunal's Approach

24. 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 Alshafey 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. When considering Dr Alshafey's evidence, the Tribunal reminded itself that Dr Alshafey is a man of good character and bore that in mind when deciding the weight it should attach to his evidence.

## The Tribunal's Analysis of the Evidence and Findings

25. 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.

### Paragraph 1

Sub-paragraph 1.a.iii.

1. On 5 November 2018 and 11 December 2018 you conducted preoperative consultations with Patient A and you failed to:

    a. conduct an adequate physical examination of Patient A on 5 November 2018 in that you did not measure and/or assess:
    **Amended under Rule 17(6)**

        iii. the presence of any abdominal scars; **Not proved**

26. The Tribunal considered whether Dr Alshafey had failed to adequately assess Patient A for the presence of abdominal scars.

27. The Tribunal was provided with no direct evidence from the GMC which demonstrated that Dr Alshafey had failed to undertake an adequate physical examination of Patient A.

28. The Tribunal had regard to the consultation letter sent to Patient A following her consultation with Dr Alshafey on 5 November 2018. There was no evidence to suggest that Patient A did not receive this letter. The Tribunal accepted that it had been produced contemporaneously and sent to Patient A. In the letter, Dr Alshafey set out the examination, both physical and visual that he completed. While there is no explicit reference to any scars Dr Alshafey noticed during the pre-operative consultation with Patient A, the letter clearly demonstrates that there was an examination performed.

29. In his witness statement, Dr Alshafey stated that Patient A "did not have any mid line, transverse, pararectal, paramedian or appendectomy scars." In oral evidence, Dr Alshafey explained that he noticed Patient A's caesarean section scar during his examination of her. Mr C, in his oral evidence, confirmed that a visual examination was sufficient to identify abdominal scars. There was no evidence in the medical records available to the Tribunal to suggest that Patient A had any other abdominal scars that Dr Alshafey failed to notice. Accordingly, the Tribunal accepted Dr Alshafey's evidence.

30. The Tribunal was satisfied that, given the examination that had been recorded in the consultation letter, Mr C's evidence and Dr Alshafey's oral evidence, Dr Alshafey had adequately assessed the presence of abdominal scars. The Tribunal therefore found sub-paragraph 1.a.iii of the Allegation not proved.

Sub-paragraphs 1.a.iv., 1.a.v., and 1.a.vi.

1. On 5 November 2018 and 11 December 2018 you conducted preoperative consultations with Patient A and you failed to:

    a. conduct an adequate physical examination of Patient A on 5 November 2018 in that you did not measure and/or assess:
    **Amended under Rule 17(6)**

        iv. the amount of skin excess; **Not proved**

        v. skin laxity; **Not proved**

        vi. the amount of subcutaneous fat; **Not proved**

31. Based on the expert evidence before it, the Tribunal was satisfied that it was appropriate to consider sub-paragraphs 1.a.iv., 1.a.v., and 1.a.vi. of the Allegation together, as all could be assessed during the same physical examination that involved pinching Patient A's skin.

32. The consultation letter stated:

> *'Today I marked the areas of liposuction and marked area of skin and fat to be removed during tummy tuck. I also explained that I will remove your existing belly button and you will have a new ( fake) one.*
>
> *Also I marked length and position of scar in front of mirror…'*

33. In his witness statement, Dr Alshafey stated *'I do not accept allegations 1.a.iii., 1.a.iv.,1.a.v., 1.a.vi. or 1a.ix… I do not accept that you can measure skin excess although I did make an assessment about her skin and in my assessment Patient A had sufficient excess skin. I examined her in front of a mirror and marked what would be excised. I pinched the two lines together to see if it would be possible to bring them together after excision and in my assessment there were enough skin laxity to perform the procedure'.*

34. In oral evidence, Dr Alshafey explained how he had pinched the skin in order to establish if there was sufficient skin to perform the abdominoplasty with liposuction before marking Patient A's skin as set out in the consultation letter. Dr Alshafey's explanation of the examination he performed to assess the amount of skin excess, skin laxity and the amount of

subcutaneous fat accorded with Mr C's evidence of how such an examination should be conducted.

35. In the absence of any direct evidence that Dr Alshafey did not perform this examination, and in light of Dr Alshafey's evidence of the assessment he carried out in accordance with the procedure described by Mr C's expert evidence, the Tribunal was satisfied that Dr Alshafey did adequately assess Patient A in respect of the amount of skin excess, skin laxity and the amount of subcutaneous fat she had.

36. The Tribunal therefore found sub-paragraphs 1.a.iv., 1.a.v., and 1.a.vi. of the Allegation not proved.

Sub-paragraph 1.a.ix.

1. On 5 November 2018 and 11 December 2018 you conducted preoperative consultations with Patient A and you failed to:

    a. conduct an adequate physical examination of Patient A on 5 November 2018 in that you did not measure and/or assess:
    **Amended under Rule 17(6)**

        ix. the amount of intra-abdominal fat; **Determined and found proved**

37. The Tribunal went on to consider whether Dr Alshafey had assessed Patient A's amount of intra-abdominal fat.

38. In oral evidence, Mr C explained the technique that should be used to assess the amount of intra-abdominal fat. He explained that the amount of subcutaneous fat would have to be established as part of the assessment of intra-abdominal fat, but that further steps were required to adequately assess intra-abdominal fat. He told the Tribunal that it was important to assess the amount of intra-abdominal fat as it cannot be treated and can only be reduced by a patient losing weight. The Tribunal accepted this evidence and found that Dr Alshafey was under a duty to assess the amount of intra-abdominal fat.

39. While there was no direct evidence provided by the GMC that Dr Alshafey did not perform an assessment of Patient A's amount of intra-abdominal fat, there was also no reference in the consultation letter from 5 November 2018 nor in Dr Alshafey's Rule 7 response or his witness statement about how he had specifically assessed intra-abdominal fat.

40. The Tribunal found that, in his witness statement, Dr Alshafey appeared to conflate the assessment of subcutaneous fat and the assessment of intra-abdominal fat.

41. In his oral evidence on this point, Dr Alshafey spoke first in general terms about how he assessed intra-abdominal fat. He then added that he had done this to Patient A on 5 November and said that this examination was useful in the assessment of how much Patient A's abdominal muscles would need tightening. The Tribunal found that this was at odds with Mr C's evidence that intra- abdominal fat (as opposed to subcutaneous fat) was not relevant to muscle tightening but could only be resolved by weight loss.

42. The Tribunal found that this was the first time that Dr Alshafey had addressed the question of assessing intra-abdominal fat and Mr C had not been asked about the technique described by Dr Alshafey.

43. The Tribunal concluded that there was no account of the intra-abdominal fat assessment Dr Alshafey said he had performed in any of the documents before it. Dr Alshafey's witness statement appeared not to distinguish between an assessment of subcutaneous and intra-abdominal fat. Accordingly, the Tribunal determined that, it was more likely than not that Dr Alshafey had failed to perform an assessment of the amount of intra-abdominal fat Patient A had.

44. The Tribunal therefore found sub-paragraph 1.a.xi. proved.

Sub-paragraph 1.b.i.

> 1. On 5 November 2018 and 11 December 2018 you conducted preoperative consultations with Patient A and you failed to:
>
> b. discuss with Patient A:
>
> i. presenting concerns; **Not proved**

45. The Tribunal considered whether Dr Alshafey had failed to discuss Patient A's presenting concerns with her.

46. The Tribunal was provided with no direct evidence from the GMC which demonstrated that Dr Alshafey had failed to discuss Patient A's presenting concerns.

47. The Tribunal had regard to the consultation letter, dated 5 November 2018 which states:

> *'Thank you for consultation today regarding liposuction of love handles and full tummy tuck.'*

48. In his witness statement Dr Alshafey stated that following his consultation with Patient A on 5 November 2018 he *'wrote to her summarising what we had discussed regarding her requirements for liposuction and an abdominoplasty'*. He also stated that '[t]*his was cosmetic treatment, and abdominoplasty was the treatment which Patient A had specifically asked for'*.

49. In his oral evidence, Dr Alshafey explained that Patient A had requested a 'tummy tuck' at the outset of the consultation on 5 November 2018. He said that Patient A explained that she wanted an abdominoplasty because people assumed she was pregnant due to the way her abdomen looked. In the medical records available to the Tribunal, it was clear that Patient A had openly discussed her desire to undergo an abdominoplasty and the reasons for it with her General Practitioner (GP).

50. The Tribunal had regard to Patient A's medical records, the confirmation of the purpose of the consultation in the consultation letter, and Dr Alshafey's recollection of the discussion about Patient A's presenting concerns in oral evidence. Taking the above into account, the Tribunal was satisfied that it was more likely than not that Patient A had repeated her presenting concerns to Dr Alshafey and that a discussion had followed on 5 November 2018.

51. The Tribunal found sub-paragraph 1.b.i. not proved.

Sub-paragraph 1.b.ii.

1. On 5 November 2018 and 11 December 2018 you conducted preoperative consultations with Patient A and you failed to:

    b. discuss with Patient A:

        ii. past medical history; **Determined and found proved**

52. The Tribunal considered whether Dr Alshafey had failed to discuss Patient A's past medical history with her.

53. In the consultation letter, dated 5 November 2018, Dr Alshafey wrote:

> *'I understand you have history of anxiety but no hx of depression nor mental illness. Non-smoker, No hx of diabetes, hepatitis, HIV, bowels or bladder symptoms.'*

54. In his first report, dated 8 December 2019, Mr C wrote:

> *'4.9… An adequate consultation would incorporate discussion regarding the patients presenting concerns, past medical history, examination, discussion regarding treatment options discussion about the procedure proposed and a discussion regarding potential side effects, risks and complications'*
>
> *4.11 Dr Alshafey does record in his typed letter to* [Patient A] *dated 5 November 2018 that he did enquire about the patients concerns and past medical history. He does not however make any recording about obstetric history, abdominal operations and weight changes'*

55. In his witness statement Dr Alshafey stated:

> *'I do not accept allegation 1.b. There was appropriate discussion and my letters sent to her contained relevant information. Although it is not recorded I did ask Patient A whether she had completed her family, as I would not have recommended this surgery for someone who was planning on having more children. I also explained the nature of the procedure, which was again discussed on the morning of the surgery, and treatment options for body contouring which included liposuction and abdominoplasty.'*

56. The Tribunal accepted that Dr Alshafey appeared to have asked Patient A a number of questions relating to her medical history that she had answered as set out in the consultation letter. However, there were also a number of matters relevant to medical history for this procedure that were absent, including information about obstetric history and previous pregnancies, abdominal operations, weight changes, current medication and allergies.

57. The Tribunal was satisfied that Dr Alshafey had a duty to discuss Patient A's past medical history with her. It was not satisfied that Patient A's past medical history listed in the consultation letter amounted to a discussion of her medical history, in part because no discussion was recorded and in part because of the clear omissions from it. It was factually inaccurate for Dr Alshafey to state that Patient A had *'anxiety'* but did not have a *'mental illness'*. Further, a discussion with Patient A about her history in terms of weight changes and current medication was likely to reveal her complex history as it related to her mental health and her weight.

58. The Tribunal concluded that Dr Alshafey appeared to have asked Patient A a set of closed questions about her past medical history as set out in the consultation letter. The Tribunal was not satisfied that such a list of questions and answers amounted to a discussion of past medical history in the circumstances of Patient A's complex past medical history or in the context of the procedure proposed. Further, it was not satisfied that the questions asked covered the most important and relevant aspects of Patient A's medical history in relation to her request to undergo an abdominoplasty.

59. The Tribunal therefore determined that sub-paragraph 1.b.ii. was proved.

<u>Sub-paragraph 1.b.iii.</u>

1. On 5 November 2018 and 11 December 2018 you conducted preoperative consultations with Patient A and you failed to:

    b. discuss with Patient A:

        iii. examination; **Not proved**

60. The Tribunal was not provided with any evidence to confirm the duty Dr Alshafey had to discuss his examination of Patient A with her, which was separate from his duty to perform an examination.

61. In the absence of any evidence of such a duty, the Tribunal found sub-paragraph 1.b.iii. not proved. For the sake of completeness, the Tribunal observed that this subparagraph of the Allegation appears to arise from a misunderstanding of paragraph 4.9 of Mr C's first report of 8 December 2019 in which he expresses the opinion that an adequate consultation would include "examination".

Sub-paragraph 1.b.iv.

1. On 5 November 2018 and 11 December 2018 you conducted preoperative consultations with Patient A and you failed to:

    b. discuss with Patient A:

        iv. treatment options; **Determined and found proved**

62. The Tribunal considered whether Dr Alshafey had failed to discussed treatment options with Patient A.

63. The Tribunal received evidence from both Dr Alshafey and Mr C about the differences between a full abdominoplasty and a 'mini' abdominoplasty. It also heard evidence from Mr C about what the treatment options for Patient A, these included no treatment and Patient A losing weight on her own, liposuction or a full abdominoplasty with liposuction.

64. There was no reference to Patient A's treatment options in the consultation letter, dated 5 November 2018. In the letter, Dr Alshafey wrote *'Please read information letter and consent form given to you today'*.

65. The Tribunal had regard to the information sheets that were provided to Patient A after her first consultation with Dr Alshafey on 5 November 2018. The Tribunal accepted that Patient A was provided with written information that included a section about *'Alternative Treatments'*. However, the Tribunal was not satisfied that Patient A being provided with written information about the procedure proposed was the same as having a discussion with Dr Alshafey about it.

66. In the consultation letter dated 11 December 2018, Dr Alshafey wrote:

> *'I understand you read information sheet given and consent form and have no questions about them.'*

67. The Tribunal was of the view that, Dr Alshafey writing that Patient A had no questions about the information sheet, confirmed that he had not had a discussion with Patient A about her treatment options either at her in person consultation on 5 November 2018 or during her telephone consultation with Dr Alshafey on 11 December 2018.

68. The Tribunal therefore found sub-paragraph 1.b.iv proved.

Sub-paragraph 1.b.v.

1. On 5 November 2018 and 11 December 2018 you conducted preoperative consultations with Patient A and you failed to:

    b. discuss with Patient A:

        v. the procedure proposed; **Not proved**

69. The Tribunal then considered whether Dr Alshafey had failed to discuss the proposed procedure with Patient A.

70. The Tribunal had regard to both consultation letters written by Dr Alshafey to Patient A. The letter dated 5 November 2018 confirms that liposuction and a full tummy tuck were the subject of the consultation and also explained that Patient A's belly button would be removed and replaced with a fake one during surgery. In the letter dated 11 December 2018, Dr Alshafey wrote *'Today I went through the steps of surgery and we will be able to book you for surgery when it is suitable for you'*.

71. The Tribunal received no evidence from Mr C to indicate that this recorded discussion of the procedure proposed fell short of the standards expected for such a discussion.

72. The Tribunal therefore concluded that Dr Alshafey had discussed the procedure proposed with Patient A. It found sub-paragraph 1.b.v. of the Allegation not proved.

Sub-paragraph 1.b.vi. (including i., ii., and iii.)

1. On 5 November 2018 and 11 December 2018 you conducted preoperative consultations with Patient A and you failed to:

    b. discuss with Patient A:

        vi. potential:

            i. side effects; **Determined and found proved**

            ii. risks; **Determined and found proved**

            iii. complications; **Determined and found proved**

73. The Tribunal considered whether Dr Alshafey had failed to discuss potential side effects, risk and complications of the procedure proposed with Patient A.

74. The Tribunal again had regard to the information sheets and consent form provided to Patient A on 5 November 2018. The Tribunal accepted that the written information provided to Patient A did set out the possible side effects, risk and complications of the procedure proposed.

75. However, there was no evidence before the Tribunal that the information in the documentation was discussed with Patient A at either of her preoperative consultations with Dr Alshafey. In his letter dated 11 December 2018, Dr Alshafey wrote *'I understand you read information sheet given and consent form and have no questions about them'*.

76. The Tribunal concluded that having provided Patient A with relevant written information did not amount to having discussed side effects, risks and complications with her. It therefore found sub-paragraph 1.b.vi proved in its entirety.

Sub-paragraphs 1.b.vii. and 1.b.viii.

1. On 5 November 2018 and 11 December 2018 you conducted preoperative consultations with Patient A and you failed to:

    b. discuss with Patient A:

        vii. obstetric history; **Determined and found proved**

        viii. abdominal operations; **Determined and found proved**

77. The Tribunal considered whether Dr Alshafey had failed to discuss Patient A's obstetric history and abdominal operations with her together.

78. Mr C's evidence was that obstetric history and abdominal operations were a key part of Patient A's past medical history. In light of the procedure proposed, the Tribunal concluded that Dr Alshafey had a duty to discuss Patient A's obstetric history and any previous abdominal operations with her.

79. The Tribunal accepted that Dr Alshafey's evidence that he had observed Patient A's caesarean section scar during his examination of her and that she had no other abdominal scars. The Tribunal also accepted his evidence that he had asked Patient A if her family was complete. However, there was no evidence before it to suggest that any discussion had taken place about Patient A's previous pregnancies, her broader obstetric history or any discussion about abdominal operations.

80. In light of the duty Dr Alshafey had to discuss Patient A's obstetric history and abdominal operations with her, and the absence of evidence that he did so, the Tribunal

determined that Dr Alshafey failed to discuss Patient A's obstetric history or abdominal operations with her during either consultation.

81. The Tribunal therefore found sub-paragraph 1.b.vii. and 1.b.viii. proved.

Sub-paragraph 1.b.ix.

1. On 5 November 2018 and 11 December 2018 you conducted preoperative consultations with Patient A and you failed to:

    b. discuss with Patient A:

        ix. weight changes. **Determined and found proved**

82. The Tribunal then considered whether Dr Alshafey had discussed Patient A's weight changes with her.

83. Mr C's evidence was that understanding Patient A's weight changes was a key part of her past medical history. In light of the procedure proposed, the Tribunal concluded that Dr Alshafey had a duty to discuss Patient A's weight changes with her.

84. Dr Alshafey told the Tribunal in oral evidence that he had asked Patient A on 5 November 2018 if her weight had been stable in the last year. He said that Patient A confirmed that it had.

85. The Tribunal was not satisfied that asking Patient A a single question about whether her weight had remained stable over the past year amounted to a discussion.

86. Given the nature of the procedure proposed and Patient A's confirmation to Dr Alshafey that she had seen plastic surgeons before about an abdominoplasty, the Tribunal was satisfied that a discussion about Patient A's history in terms of her weight and how it had changed was required. Further, while he did not know of Patient A's complex history as it related to her mental health and her weight at the time, a discussion about her weight history, may have led to this information being disclosed.

87. The Tribunal found sub-paragraph 1.b.ix. proved.

## Paragraph 2

Sub-paragraph 2.a.ii.

2. On 5 January 2019 you performed an abdominoplasty combined with liposuction and fat grafts on Patient A ('the Procedure') and:

    a. you failed to:

ii. adequately record who administered the local anaesthetic to Patient A; **Not proved**

88. The Tribunal considered whether Dr Alshafey had failed to adequately record who had administered the local anaesthetic to Patient A.

89. In his first report, Mr C wrote that it was *'unclear'* who administered the local anaesthetic to Patient A. However, the Tribunal was not provided with any evidence of Dr Alshafey being under a duty to adequately record who administered the local anaesthetic to Patient A.

90. Dr Alshafey stated in his witness statement *'I prepared and administered the local anaesthetic to Patient A but I did not record this'*.

91. During cross-examination, Mr C was informed of Dr Alshafey's evidence that he administered the local anaesthetic himself. Having received this additional information, Mr C agreed with Mr Holl-Allen that if Dr Alshafey administered the local anaesthetic himself, as he was the surgeon performing the Procedure, it was not necessary for him to record separately who had administered the local anaesthetic.

92. The Tribunal accepted the evidence of both Dr Alshafey and Mr C. The Tribunal therefore determined that Dr Alshafey had not failed to adequately record who administered the local anaesthetic, because it accepted that he administered it himself.

93. The Tribunal found sub-paragraph 2.a.ii. not proved.

<u>Sub-paragraph 2.a.iv.i</u>

2. On 5 January 2019 you performed an abdominoplasty combined with liposuction and fat grafts on Patient A ('the Procedure') and:

    a. you failed to:

        iv. ensure:

            i. you had supervision from an appropriately trained and accredited surgeon whilst performing the Procedure; **Determined and found proved**

94. The Tribunal considered whether Dr Alshafey had failed to ensure he had supervision from an appropriately trained and accredited surgeon whilst performing the Procedure.

95. In his first report, Mr C wrote:

> *'1.6 Whilst I accept that the credentialing guidelines were not in place at the time Dr Alshafey undertook the index procedure, it is my opinion based on the information*

*available to me that he would not be considered by a reasonable body of cosmetic surgeons to have had an adequate training in abdominoplasty or to have the competence required to perform the procedure without the supervision of an appropriately trained and accredited surgeon.'*

96. The Tribunal accepted Mr Holl-Allen's submission that it must be cautious of 'double counting' Dr Alshafey's admission that the failed to undertake adequate training prior to the Procedure, in also considering his failure to be supervised. Nevertheless, at this stage the Tribunal was satisfied that it amounted to a proper and separate allegation.

97. The Tribunal had regard to Dr Alshafey's evidence about the training he had undertaken prior to performing the Procedure. He told the Tribunal that he had prepared for the Procedure over a period of two years by reading relevant books and seeking out training in the UK and internationally. He completed a two-day training programme in the United States of America (USA), where he was involved in one abdominoplasty procedure. Mr C's evidence was that the training course Dr Alshafey completed was an adequate introduction to abdominoplasty surgery, but was not sufficient training to allow Dr Alshafey to complete abdominoplasty surgery without supervision.

98. Dr Alshafey was asked by the Tribunal to explain his previous surgical experience. He told the Tribunal about the surgeries he had undertaken while working in various positions within Obstetrics and Gynaecology. Dr Alshafey confirmed in oral evidence that he had not performed open surgery without supervision (i.e. a Consultant was always in the hospital and available should complications have arisen). He had only done minor procedures unsupervised. Dr Alshafey confirmed that prior to his two day training in 2018, he had not undertaken any open surgery since he left Obstetrics and Gynaecology in 2013.

99. The Tribunal was satisfied that given his lack of adequate training or experience as a surgeon undertaking abdominoplasties, Dr Alshafey had a duty to be supervised. Dr Alshafey was not supervised during the Procedure, the Tribunal determined that Dr Alshafey had failed to be appropriately supervised.

100. The Tribunal found sub-paragraph 2.a.iv.i. proved.

<u>Sub-paragraph 2.a.vi.ii.</u>

2. On 5 January 2019 you performed an abdominoplasty combined with liposuction and fat grafts on Patient A ('the Procedure') and:

    a. you failed to:

        iv. ensure:

            ii. that the premises in which you performed the Procedure were safe; **Determined and found proved**

101. The Tribunal went on to consider whether Dr Alshafey failed to ensure that the premises in which he performed the Procedure were safe.

102. The Tribunal first considered whether Dr Alshafey had a duty to ensure that the premises in which he performed the Procedure were safe.

103. The Tribunal reminded itself that on the day of the Procedure, Dr Alshafey held two roles at the Clinic, he was the Registered Manager with the CQC and was also the surgeon in charge.

104. In his first report, Mr C referred to the 'Guidance for doctors who offer cosmetic interventions' (2016) ('the Guidance'). The Tribunal had regard to paragraph 28 in the Annex under the heading *'Doctors with extra responsibilities'*:

> *'28 If you have a management role or responsibility, you must make sure that systems are in place to give early warning of any failure, or potential failure, in the clinical performance of individuals or teams. These should include systems for conducting audits and considering patient feedback. You must make sure that any such failure is dealt with quickly and effectively.'*

105. The GMC relied on the CQC Report to prove that the premises were not safe at the time of the Procedure.

106. In response to a question from the Tribunal, Dr Alshafey confirmed that there were no significant differences between the premises in June 2019, when the CQC inspected the Clinic and in January 2019 when he performed the Procedure.

107. Having heard that there were not any material differences in the premises between January and June 2019, the Tribunal was satisfied that it could consider the evidence within the CQC Report when considering this sub-paragraph of the Allegation.

108. In her witness statement, Ms B stated *'During the inspection of the clinic we found that there were a number of areas of unsafe practice and the environment was not clean or fit for purpose… I arrived for the inspection at 9am in the morning, as the day progressed I became more concerned about what I was seeing… I needed some senior support as it was likely that we were going to take some enforcement action'*.

109. The CQC Report sets out that surgical procedures are a regulated activity and fall under:

> Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
>
> 1. All premises and equipment used by the service provider must be
>
> a. Clean

b. Suitable for the purpose for which they are being used
e. properly maintained, and

2. The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used.

110. The Tribunal considered the following CQC conclusions to be particularly relevant to its assessment of safety of the premises:

- *'The premises did not appear to be clean, there were no cleaning schedules available… no water flushing was taking place.'*
- *'The design, maintenance and use of facilities, premises and equipment did not keep people safe. Staff did not manage clinical waste well and substances hazardous to health were not risk assessed and stored securely.'*
- *'Random checks of decontaminated equipment were made and two were found to have expired in February and September of 2018. This meant the service could not guarantee the integrity of instruments.'*
- *'The consultation room had a desk, chair, a bed and assorted furniture. In this room a plug with trailing wires was a potential trip hazard. This was positioned under the water fountain and posed a hazard to water splashing as there was no drip tray. This was a potential electrocution risk and was bought to the attention of the staff during the inspection.'*
- *'The environment did not appear clean. Dust was seen in the hallways and procedure room. The consultation room had dust on high and low surfaces. Wall mounted cupboards on the first-floor landing could not be closed due to the condition of the doors. The inside of these cupboards were thick with dust.'*
- *'In the procedure room and theatre, there was no coving which meant the flooring was not compliant with the Department of Health's Health Building Note (HBN) 00-09: Infection control in the built environment. In clinical areas there should be a continuous return between the floor and wall to allow for easy cleaning.'*
- *'The hallway from theatre to the toilets had carpet which could not be easily cleaned when spills occurred. Department of Health's Hospital Building Note (HBN) 00-09: infection control in the built environment states 'Spillage can occur in all clinical areas, corridors and entrances' and 'in areas of frequent spillage or heavy traffic, they can quickly become unsightly'. During the procedure we observed the patient walking from theatre to the toilet and leaking fluid from wounds was seen running into the carpet.'*
- *'There were no cleaning schedules available. The cleaning was carried out by the practice manager and doctor using a detergent and chlorine disinfectant. We were told this was done on a daily basis and in theatre after each patient, however there were no records of this. There were no cleaning audits.'*
- *'There was no resuscitation trolley but there was a box in theatre containing a range of needles and one cannula and infusion set to administer medications directly into the vein. There was a limited range of equipment to maintain a*

*patients airway, there were airways from baby to adult size, and an adult face mask this was the only means of administering oxygen if required.'*

- *'The box contained a bag of intravenous fluid (Gelofusin) that expired in 2017, the only medication it contained was injectable adrenaline. There was an information sheet on chlorphenamine but no medication.'*
- *'Three of the rooms on the premises did not contain a sink for hand washing. This included the decontamination room, consultation room where patients would be cared for pre and post operatively. The procedure room had no sink and staff told us this room might be used for minor surgical procedures.'*

111. In answer to a question from the Tribunal, Dr Alshafey confirmed that he had not enquired about the suitability of his premises for the Procedure during his abdominoplasty training in the US. He had also not confirmed with the CQC that they were safe to perform abdominoplasties in.

112. The CQC Report set out the dates that some of the equipment expired. Those dates were prior to the Procedure in January 2019.

113. Taking all of the above into account, the Tribunal was satisfied that, Dr Alshafey had a duty as the doctor carrying out the procedure on 15 January 2019 to ensure that the premises were safe.

114. Having read to all the examples set out in the CQC report, which were not challenged, the Tribunal determined that Dr Alshafey had failed to ensure that the premises were safe.

115. The Tribunal found sub-paragraph 2.a.vi.ii. proved.

Sub-paragraph 2.b. (including i. and ii.)

2. On 5 January 2019 you performed an abdominoplasty combined with liposuction and fat grafts on Patient A ('the Procedure') and:

    b. by not having the adequate training in performing the abdominoplasty procedure you put Patient A at risk of:

        i. serious harm; **Determined and found proved**

        ii. life threatening consequences. **Determined and found proved**

116. The Tribunal considered whether Dr Alshafey had put Patient A at risk of serious harm and/or life threatening consequences having performed the Procedure without adequate training.

117. The Tribunal had regard to Mr C's evidence in his report dated 9 July 2020 at paragraph 1.7.

*'In respect of Dr Alshafey's lack of surgical training and expertise in general and in particular his inadequate lack of training in performing the abdominoplasty procedure I consider his conduct fell seriously below the standard expected. In my opinion his failure was of such a magnitude i.e. sufficient to cause or potentially cause serious harm or life threatening consequences for the patient under his care.'*

118. In oral evidence, Mr C described the UK training pathway for cosmetic surgery, which included general surgical training and plastic surgery training prior to learning cosmetic surgery techniques. Mr C explained that adequate surgical training does not just apply to the surgery itself. He said that adequate training included: first, selecting the correct operation for the patient with a sound rationale; second, performing the surgery; and third, providing appropriate postoperative care and adequately managing any complications.

119. The Tribunal had careful regard to Mr Holl- Allen's submission that this sub-paragraph referred to the risk to Patient A on 15 January 2019 only. The Tribunal accepted that the sub paragraph was confined to risks arising from undertaking the procedure on 5 January but found it was not confined to the risk of adverse consequences arising on that day.

120. While there was no evidence that Dr Alshafey performed the Procedure incorrectly, he had not performed any open surgery between 2013 and 2018, when he completed his two days training in the USA.

121. The Tribunal accepted the evidence of Mr C that abdominoplasty surgery is a major surgery with significant risks. He told the Tribunal that it is a surgery that has a higher mortality rate than many other major surgeries and that there is a higher risk of serious complications such as catastrophic blood loss and wound infection. The Tribunal found that such risks amounted to a risk of serious harm and life threatening consequences.

122. The Tribunal accepted that credentialling did not come into place until after the Procedure. However, such credentialling was put in place to reduce risk of harm to patients. Had credentialling been in place when Dr Alshafey performed the Procedure, he would have needed 30 credits, he had 1.25.

123. In his self-referral to the GMC, dated 19 January 2019, Dr Alshafey wrote:

*'Serious Incident : I have done a surgical error during performing abdominoplasty privately, where I left a layer of fat on rectus sheath that was entrapped during plication of sheath that resulted in fat necrosis and secondary infection and sepsis that led to prolonged hospital admission and skin and fat loss.'*

124. When he referred himself to the GMC, Dr Alshafey believed that his technique had led to Patient A's serious infection. However, Mr C's expert opinion was that there was no evidence of a deficit in Dr Alshafey's technique during the Procedure itself.

125. The Tribunal was of the view that at the time of Dr Alshafey's self-referral, he demonstrated his lack of training and understanding of what occurred during the Procedure, what went wrong and what led to the serious consequences for Patient A.

126. In his oral evidence, Dr Alshafey accepted that he had never performed major surgery unsupervised.

127. The Tribunal reminded itself that it had to determine the risk created by Dr Alshafey undertaking a procedure in respect of which he was not properly trained and not the consequences. The Tribunal was satisfied that by undertaking a procedure for which he was not adequately trained, in particular in the context of the absence of training and experience in general or plastic surgery and the length of time since he last performed open surgery, there was an irresistible inference Dr Alshafey increased the risk of an adverse outcome. The tribunal also accepted the unchallenged evidence that in this case those risks included catastrophic blood loss and mortality.

128. Taking all of the above into account, the Tribunal determined that Dr Alshafey's lack of adequate training had put Patient A at risk of serious harm and life-threatening consequences.

Paragraph 3

Sub-paragraph 3.a.i.i

3. On 15 January 2019 you consulted with Patient A and you failed to provide adequate postoperative care, in that you:

    a. failed to:

        i. detect:

            i. skin necrosis; **Not proved**

129. The Tribunal considered whether on 15 January 2019, Dr Alshafey had failed to provide adequate postoperative care to Patient A in that he failed to detect skin necrosis and/or impending necrosis.

130. The Tribunal had regard to Patient A's medical records. On the 8 January 2019 when she was admitted to Stoke Mandeville Hospital, the Accident and Emergency (A&E) doctor she saw wrote *'Middle of the incision- skin around looks black/ dark/ necrotic. Skin warm to touch around the incision'*. Patient A was subsequently seen by the Consultant Plastic Surgeon on 9 January 2019, who did not refer to or record any reference to skin necrosis. The Tribunal was satisfied that given the additional relevant experience the Consultant Plastic Surgeon would have in identifying skin necrosis, that skin necrosis would have been recorded

if present. Accordingly, the Tribunal concluded that skin necrosis was not present when Patient A attended Stoke Mandeville.

131. Dr Alshafey wrote in an email to Mr E, the surgeon with whom he trained in the USA on 15 January 2019 *'I saw her there on day 7 there was some skin necrosis in the mid-section of the wound exactly around 6cm in length and 2cm in height'*. In oral evidence, he explained that his email focused on his fear that Patient A could potentially develop skin necrosis, not that she already had it. Dr Alshafey was not challenged about his view under cross-examination.

132. In comments about the Procedure he provided to the GMC on 3 March 2019, Dr Alshafey wrote:

> 'On day of follow up at Epsom office wound looked necrotic and smelly and infected.'

133. Dr Alshafey explained in oral evidence that Patient A had necrotic fat on 15 January 2019, not skin necrosis. The Tribunal accepted Dr Alshafey's unchallenged evidence on this point.

134. In the absence of any further evidence from Patient A's records from her stay at Stoke Mandeville Hospital about skin necrosis, and considering Mr C's acceptance that *'the fact of whether or not there was necrotic skin present is questionable given the conflicting records between the A&E Doctor… and the Plastic Surgeons.'*, the Tribunal found that on the balance of probabilities, Patient A did not have skin necrosis on 15 January 2019 and that therefore, Dr Alshafey could not be said to have failed to detect it.

135. The Tribunal found sub-paragraph 3.a.i.i. not proved.

<u>Sub-paragraph 3.a.i.ii.</u>

3. On 15 January 2019 you consulted with Patient A and you failed to provide adequate postoperative care, in that you:

    a. failed to:

        i. detect:

            ii. impending necrosis; **Not proved**

136. The Tribunal then considered whether Dr Alshafey had failed to detect impending necrosis.

137. The Tribunal was not provided with direct evidence of how Dr Alshafey failed to detect impending necrosis.

138. The Tribunal noted Dr Alshafey's his email to Mr E that referred to potential skin necrosis. In his self-referral, he also mentioned the wound looking *'necrotic'*. Further, in his oral evidence, Dr Alshafey gave clear and compelling evidence that he was concerned about Patient A's fat necrosis from the 12 January 2019 postoperative consultation onwards.

139. The Tribunal concluded that there was clear evidence that Dr Alshafey was concerned about the possibility of impending necrosis and recognised that it was a possible complication and that this concern was documented in his email to Mr E.

140. The Tribunal therefore found sub-paragraph 3.a.i.ii. not proved.

Sub-paragraph 3.a.iv.

3. On 15 January 2019 you consulted with Patient A and you failed to provide adequate postoperative care, in that you:

    a. failed to:

        iv. establish the cause of Patient A's infection; Not proved

141. The Tribunal considered whether Dr Alshafey had failed to establish the cause of Patient A's infection.

142. The Tribunal reminded itself that Dr Alshafey had admitted sub-paragraph 3.a.iii. that he failed to ensure that the results of Patient A's microbiology were identified.

143. The Tribunal accepted that Dr Alshafey recognised that Patient A had a wound infection on 15 January 2019.

144. The Tribunal was of the view that the only way to establish the specific bacteria causing Patient A's wound infection was to review the results of the microbiology testing Patient A had. Having admitted that he failed to do this, the Tribunal concluded that sub-paragraph 3.a.iv. was simply another way to allege the same failing as set out in sub-paragraph 3.a.iii.

145. The Tribunal therefore found sub-paragraph 3.a.iv. not proved.

Sub-paragraph 3.a.v.

3. On 15 January 2019 you consulted with Patient A and you failed to provide adequate postoperative care, in that you:

    a. failed to:

v. recognise the potential risk of Patient A's infection developing into necrotising fasciitis; **Determined and found proved**

146. Mr C stated in his first report that '*Dr Alshafey should have recognised the potential risk of the infection developing into necrotizing fasciitis a condition with a high mortality rate'*.

147. The Tribunal had regard to the joint expert report which confirmed that Patient A was exhibiting signs of NF on 8 January 2019:

> *'1.9 In the early stage's diagnosis can be difficult to differentiate from other types of infection…*
>
> *1.20 Patient A showed clinical signs of a significant wound infection with dressings soaked with blood and serous fluid, complained of pain, and had infection with a description of the skin looking black, dark, and necrotic.*
>
> *1.21 These clinical signs and symptoms would be compatible with a severe wound infection or NF.'*

148. However, the experts agreed that the subsequent notes from 12 and 15 of January 2019 did not record any descriptions that would be *'compatible or indicative of NF'*. They agreed that on 15 January 2019, Dr Alshafey's description of the wound was *'compatible or indicative of a significant wound infection that in his opinion required surgical debridement'*. They also agreed that '*Given the degree of progression of the wound infection in 3 days from 'superficial' to one that required debridement NF should have been considered in the differential diagnosis'*.

149. The Tribunal understood the expert criticism of Dr Alshafey in respect of NF that he had not recognised that Patient A's significant deterioration between 12 and 15 January 2019 and that he should have recorded NF as a differential diagnosis and had not done so.

150. In oral evidence, Dr Alshafey had said that he had seen NF once before, that he had read about it and that he knew it was very serious. However, the Tribunal was not persuaded that Dr Alshafey's actions on 15 January 2019 reflected that concern. Following his postoperative consultation with Patient A he had sent her away and booked her in for a debridement of the necrotic fat in the infected wound in five days time. Such a decision did not demonstrate any concern about Patient A's urgent need for a debridement nor did it demonstrate that Dr Alshafey understood the potential risk of the infection developing into NF given Patient A's swift wound deterioration.

151. The Tribunal concluded that if Dr Alshafey had recognised the risk of Patient A's infection developing into necrotising fasciitis, he would not have decided that she could wait five days for a debridement of the wound. It therefore determined that Dr Alshafey had failed to recognise the potential risk of NF.

152. The Tribunal found sub-paragraph 3.a.v. proved.

Sub-paragraph 3.a.vi.

3. On 15 January 2019 you consulted with Patient A and you failed to provide adequate postoperative care, in that you:

    a. failed to:

        vi. prescribe appropriate antibiotics; **Not proved**

153. The Tribunal reminded itself that Dr Alshafey admitted that he had failed to ensure the results of Patient A's microbiology were identified.

154. The Tribunal accepted that in order to prescribe appropriate antibiotics, Dr Alshafey would have needed to consider Patient A's microbiology results to ensure the bacteria present in her wound infection were identified and an antibiotic to which these bacteria were sensitive and responsive to was prescribed. Dr Alshafey conceded in his evidence that he should have chased up Patient A's microbiology and that he had not.

155. In his report, Mr C wrote:

> *'Microbiology cultures taken from 15 and 16 January 2019 confirmed a growth of multiple bacteria; Enterococcus Faecalis, Morganella morganii, Proteus mirabllis and Pseudomonas. There was also a positive culture of mixed anaerobes. Only two of the bacteria identified were sensitive to the antibiotic prescribed by Dr Alshafey'*

156. The Tribunal examined the medical records and found that the results derived from the cultures referred to by Mr C were not available to Dr Alshafey on 15 January 2019. Accordingly, the Tribunal found there was no basis upon which it could find that Dr Alshafey had failed to respond to results that were not available to him. The only cultures available to him were those obtained on 8 January 2019 and there is no evidence that he prescribed inappropriately in the light of the results obtained from those cultures.

157. The Tribunal found sub-paragraph 3.a.vi. not proved.

Sub-paragraph 3.a.viii.

3. On 15 January 2019 you consulted with Patient A and you failed to provide adequate postoperative care, in that you:

    a. failed to:

        viii. arrange for a further review within 48 hours to confirm that Patient A's infection was not worsening; **Determined and found proved**

158. The Tribunal considered whether Dr Alshafey had failed to provide adequate postoperative care in that he did not arrange a further review of Patient A within 48 hours to confirm that her infection was not worsening.

159. Mr Holl-Allen submitted that this sub-paragraph of the Allegation should properly be found not proved due to Dr Alshafey's admission at sub-paragraph 3.a.vii. that the appropriate management of Patient A on 15 January was to arrange her urgent admission to hospital.

160. The Tribunal did not accept this submission because factually, Dr Alshafey had failed to arrange Patient A's urgent admission to hospital and had agreed a different management plan, namely that in five days time, Patient A would attend his Clinic for a debridement of her wound.

161. Dr Alshafey had been sufficiently worried about the state of Patient A's wound on 12 January 2019, following their appointment on 8 January 2019 and notification from Stoke Mandeville that she had been admitted to hospital, to advise that she return for a further postoperative consultation within 48 hours. Due to Patient A's apparent unavailability to travel, the postoperative consultation was in fact scheduled for 15 January 2019.

162. Having recorded that Patient A's wound had deteriorated between 12 and 15 January 2019, Dr Alshafey then failed to book Patient A in for a further consultation within 48 hours to ensure that her infection was not worsening. This was further supported by Mr C's opinion that *'I consider that Dr Alshafey's advice on 15 January 2019 to plan for wound debridement in 5 days' time in the absence of any knowledge of the cause of the infection was inadequate and inappropriate'*.

163. Given the deterioration, the Tribunal was satisfied that Dr Alshafey had a duty to arrange a further consultation within 48 hours. Patient A's management plan as arranged by Dr Alshafey, with a wait of five days, was not sufficient to address the significant worsening of her infection. Whether or not he now accepts that Patient A should have been sent straight to hospital does not negate that this own plans for her postoperative care were inadequate.

164. The Tribunal therefore found sub-paragraph 3.a.viii proved.

<u>Sub-paragraph 3.b. (including i., ii., and iii.)</u>

3. On 15 January 2019 you consulted with Patient A and you failed to provide adequate postoperative care, in that you:

    b. put Patient A at risk of the following by failing to undertake the actions as set out at paragraph 3.a.:

        i. severe harm; **Determined and found proved**

ii. significant morbidity; **Determined and found proved**

iii. life threatening changes. **Determined and found proved**

165. The Tribunal considered whether any, some or all of Dr Alshafey's actions that had been found proved in paragraph 3.a. put Patient A at risk of severe harm, significant morbidity or life threatening changes.

166. The Tribunal had regard to the following paragraphs of Mr C's first report:

> '*4.44 In my opinion Dr Alshafey's postoperative care of* [Patient A] *between 12 and 15 January 2019 was inadequate and due to the potential risk of severe harm to* [Patient A] *falls seriously below the standard expected.*
>
> *4.45 Dr Alshafey should have recognised the potential risk of the infection developing into necrotising fasciitis, a condition with a high mortality rate. He should have arranged for urgent admission to hospital for close observation and urgent exploration and debridement of the wound…*
>
> *4.52 In view of the fact that this put* [Patient A] *at risk of significant morbidity and possible life threatening changes I consider that in this respect Dr Alshafey's conduct fell seriously below the standard expected'.*

167. In respect of NF, which the Tribunal has found that Dr Alshafey failed to recognise the potential risk of, the joint expert report states:

> *'1.4 Necrotising fasciitis has significant morbidity and mortality with between 25-35% of patients dying as a result of the infection.'*

168. The experts also agreed that there was clear evidence that Patient A showed clinical signs of a severe wound infection.

169. The expert evidence on these matters was not challenged. Mr C's evidence was not challenged or contradicted by Mr D who was instructed on behalf of Dr Alshafey to provide expert evidence.

170. In light of the unchallenged expert evidence, and its previous findings in respect of paragraph 3.a. the Tribunal was satisfied that Dr Alshafey had put Patient A at risk of severe harm, significant morbidity and life threatening changes by providing inadequate postoperative care.

171. The Tribunal therefore found sub-paragraph 3.b. proved in its entirety.

<u>Paragraph 4</u>

Sub-paragraph 4.a.

4. In the alternative to paragraphs 1-3 above you failed to record having undertaken the actions as outlined at paragraph:

    a. 1.a.; **Determined and found proved in respect of sub-paragraphs 1.a.iii., iv., v., and vi.**

172. The Tribunal noted that this paragraph of the Allegation was 'in the alternative'. It therefore considered that this charge only related to those matters which had not been found proved under the paragraph 1.a.

173. Paragraphs 1.a.i., 1.a.ii., 1.a.vii., and 1.a.viii. of the Allegation were found proved at paragraph 1.a. of the Allegation. Therefore, the Tribunal found these subsections not proved in relation to 4.a.

174. In relation to the remaining sub-paragraphs under 1.a., the Tribunal had accepted that Dr Alshafey had measured and/or assessed: the presence of any abdominal scars; the amount of skin excess; skin laxity; and the amount of subcutaneous fat. Despite the evidence of such assessments arising from Dr Alshafey's letters, the Tribunal accepted Mr C's clear evidence that a letter did not amount to a record. In the absence of records beyond the letters, it determined that these areas were found proved.

175. The Tribunal therefore found sub-paragraph 4.a. of the Allegation proved in relation to 1.a.iii., 1.a.iv., 1.a.v., and 1.a.vi.

Sub-paragraph 4.b.

4. In the alternative to paragraphs 1-3 above you failed to record having undertaken the actions as outlined at paragraph:

    b. 1.b.; **Determined and found proved in respect of paragraphs 1.b.i. and v.**

176. The Tribunal noted that this paragraph of the Allegation was 'in the alternative'. It therefore considered that this charge only related to those matters which had not been found proved under the paragraph 1.b.

177. The Tribunal noted that paragraphs 1.b.ii., 1.b.iv., 1.b.vi.i., 1.b.vi.ii., 1.b.vi.iii., 1.b.vii., 1.b.viii., and 1.b.ix. of the Allegation had been found proved under paragraph 1.b. of the Allegation. The Tribunal therefore found 4.b. not proved in relation to these sub-paragraphs.

178. The Tribunal concluded that, aside from matters contained within his letters, Dr Alshafey had failed to record discussions in relation to Patient A's presenting concerns and the procedure proposed. However, it found that in the absence of any evidence to confirm

the duty Dr Alshafey had to discuss his examination of Patient A with her, a lack of record detailing such a discussion did not amount to a failure.

179. The Tribunal therefore found sub-paragraph 4.b. of the Allegation proved in relation to 1.b.i. and 1.b.v. only.

Sub-paragraph 4.c.

4. In the alternative to paragraphs 1-3 above you failed to record having undertaken the actions as outlined at paragraph:

    c. 2.a.iii.; Not proved

180. The Tribunal found that sub-paragraph 2.a.ii. had been admitted and found proved under paragraph 2 of the Allegation.

181. The Tribunal therefore found sub-paragraph 4.c. of the Allegation not proved.

Sub-paragraph 4.d.

4. In the alternative to paragraphs 1-3 above you failed to record having undertaken the actions as outlined at paragraph:

    d. ~~2.a.iv.2.~~ 2.a.iv.1.; Not proved
    Amended under Rule 17(6)

182. The Tribunal considered its finding that sub-paragraph 2.a.iv.i/1 had been found proved in relation to paragraph 2 of the Allegation.

183. The Tribunal therefore found sub-paragraph 4.d. of the Allegation not proved.

Sub-paragraph 4.e.

4. In the alternative to paragraphs 1-3 above you failed to record having undertaken the actions as outlined at paragraph:

    e. 3.a.. Not proved

184. The Tribunal took into account its findings under paragraph 3 of the Allegation. It noted that, as the remainder of the sub-paragraphs had been found proved, the focus of its considerations under sub-paragraph 4.e. was in relation to 3.a.i.i., 3.a.i.ii., and 3.a.iv.

185. In relation to sub-paragraphs 3.a.i.i. and 3.a.i.ii., the Tribunal considered that as Dr Alshafey did not detect skin necrosis nor impeding skin necrosis, he did not record this. However, the Tribunal was not satisfied that Dr Alshafey was obliged to record what he had not found and therefore did not consider it to be a failure.

186. In light of the Tribunal's findings in relation to sub-paragraph 3.a.iv, it found the same sub-paragraph under 4.e. not proved.

187. The Tribunal therefore found sub-paragraph 4.e. of the Allegation not proved in its entirety.

Paragraph 5

5. You failed to record any postoperative instructions. **Not proved**

188. In his first report, Mr C wrote '*There are no postoperative instructions recorded. Failure to so falls below the standard expected*'

189. In respect of this paragraph of the Allegation, in cross-examination, Mr C's attention was drawn to a complete record of Patient A's postoperative notes that he had not previously had sight of.

190. Mr C reviewed the postoperative notes written by Dr Alshafey and withdrew his criticism that Dr Alshafey had failed to record any postoperative instructions. The Tribunal accepted that Dr Alshafey had recorded postoperative instructions.

191. The Tribunal therefore found paragraph 5 of the Allegation not proved.

Paragraph 6 - Liposuction Procedure

Sub-paragraph 6.a.i.

6. On 13 June 2019 you performed liposuction on a patient ('the Liposuction Procedure') and you:

    a. failed to:

        i. hold an up to date qualification in intermediate or advanced life support; **Determined and found proved**
        **Amended under Rule 17(6)**

192. The Tribunal considered whether Dr Alshafey had a duty to hold an up to date qualification in intermediate or advanced life support when he performed the Liposuction Procedure.

193. On 13 June 2019, the Clinic underwent a CQC inspection, during which time a patient was in attendance having a liposuction procedure.

194. The Tribunal had regard to the CQC report which states:

*'Both doctors, undertaking surgery, did not have an up to date qualification in intermediate or advanced life support. This was not in line with current standards and guidance by the Academy of Medical Royal Colleges.'*

195. The Tribunal reminded itself of Ms B's evidence, which had not been challenged, that Dr Alshafey had received a copy of the CQC Report to review and challenge prior to it being confirmed as accurate and published.

196. In his first supplementary report, Mr C wrote:

*'2.3 The doctors undertaking the surgery did not have an up to date qualification in intermediate or advanced life support. This was not in line with current standards and guidance by the Academy of Medical Colleges.*

*2.4 Doctors undertaking surgical procedures should maintain current standards and guidance from the Academy of Medical Colleges in respect of life support. It is not unreasonable however to accept that a doctor that has worked in an acute medical speciality such as Obstetrics and gynaecology for a number of years would have an adequate knowledge of life support.*

*2.5 In my opinion the doctor's failure to have an up to date qualification in life support falls below but not seriously below the standard expected. The failure did not or was not likely to result in a serious or significant breach of the GMC guidelines or to cause significant harm to the patient.'*

197. In oral evidence, Mr C confirmed his view that Dr Alshafey was unlikely to have placed Patient A at risk as he would have had an adequate knowledge of life support from his previous experience in an acute medical speciality. During cross-examination, he accepted that as the Liposuction Procedure was conducted under local anaesthetic the need for an intermediate or advanced life support qualification was lessened as the patient remained alert and awake throughout.

198. The Tribunal accepted that Dr Alshafey, along with all other staff at the Clinic had undergone a day of mandatory training which included basic life support. However, the Tribunal did not have any evidence of what that basic life support training covered. It also had regard to the length of time Dr Alshafey had been working outside of an acute medical speciality when he performed the Liposuction Procedure.

199. The Tribunal concluded that the duty set out in the current standards and guidance from the Academy of Medical Colleges in respect of the requirement to hold an intermediate or advanced life support qualification applied to Dr Alshafey.

200. As Dr Alshafey did not hold an intermediate and advanced life support qualification, the Tribunal found sub-paragraph 6.a.i. proved.

Sub-paragraph 6.a.iii.

6. On 13 June 2019 you performed liposuction on a patient ('the Liposuction Procedure') and you:

    a. failed to:

        iii. ascertain preoperatively if the patient had any known allergies;

Not proved

201. The Tribunal considered whether Dr Alshafey had failed to ascertain preoperatively whether the patient who underwent the Liposuction Procedure had any known allergies.

202. In the CQC Report it was stated:

*'We observed that it was halfway through the procedure that the patient was asked about any allergies.'*

203. The Tribunal reminded itself of the evidence of Ms B, that she herself was not present during the Liposuction Procedure and had not witnessed this interaction herself.

204. Ms B suggested that the liposuction patient had gone straight into theatre when she arrived at the Clinic on 13 June 2019. Dr Alshafey gave evidence that the patient was first seen in the consultation room where she got changed and a conversation was had which he said would have included confirmation that she had no known allergies.

205. The Tribunal preferred Dr Alshafey's evidence and accepted that it was more likely than not that the patient had first gone into the consultation room.

206. The Tribunal had no evidence from the liposuction patient, either in the form of a statement or in terms of access to her medical records. The Tribunal therefore did not know what she had been asked and whether, for example, during her preoperative consultation, any allergies had been discussed. It also reminded itself that the CQC had not been present to observe any of Dr Alshafey's preoperative consultations with the liposuction patient.

207. The Tribunal concluded that it did not have sufficient evidence to conclude that the first and only time the liposuction patient had been asked about any known allergies was during the Liposuction Procedure.

208. The Tribunal found sub-paragraph 6.a.iii. not proved.

Sub-paragraph 6.a.vi.i

6. On 13 June 2019 you performed liposuction on a patient ('the Liposuction Procedure') and you:

    a. failed to:

        vi. ensure that the:

            i. staff assisting with the Liposuction Procedure were trained operating assistants who could identify basic clinical signs; **Not proved**

209. The Tribunal considered whether Dr Alshafey had failed to ensure that the staff assisting with the Liposuction Procedure were trained operating assistants who could identify basic clinical signs.

210. The Tribunal had regard the CQC Report that stated:

'*We were concerned about the skills and expertise of the practice manager assisting the doctor and their ability to support in the care of a deteriorating patient. When they were asked about how they would take patient observations they were unaware of what respiratory rate was and how this was measured*'

211. Mr C, in his first supplementary report wrote:

'*2.13 Staff assisting a surgeon to undertake a surgical procedure should have an appropriate and adequate knowledge of aseptic technique and the monitoring of basic clinical signs such as how to take and record pulse rate, temperature, blood pressure and respiration rate. The normal range of values for these clinical signs should be understood and a clear knowledge of what to do if the signs are outside the normal range. A knowledge of levels of patient consciousness should also be understood and what to do if levels drop.*

*2.14 A surgical assistant would normally be trained as a nurse or operating department practitioner. Undertaking a five hour operation without a trained operating assistant who was unable to identify basic clinical signs would in my opinion fall seriously below the standard expected of a reasonably competent cosmetic surgeon. Given the potential risk to the patient I consider this falls seriously below the standard expected.'*

212. It was Dr Alshafey's evidence that the person referred to as the *'practice manager'* in the CQC report was the Clinic's Health Care Assistant (HCA). Dr Alshafey was clear that his HCA could and did monitor basic clinical signs during the Liposuction Procedure, though they were not recorded. The same person was also referred to as an HCA in the CQC Report.

213. Mr C accepted under cross-examination that an HCA would have the appropriate training to monitor the basic clinical signs required during the Liposuction Procedure.

214. The Tribunal was mindful that it had not been provided with any evidence to suggest that Dr Alshafey had a duty to ensure that during the Liposuction Procedure he was assisted by a trained operating assistant, rather than an HCA. The Tribunal was also mindful that it had no direct evidence of what the CQC Inspector had asked the HCA, what her answer was and how it had been concluded that she was unaware of what respiratory rate was and how it was measured.

215. The Tribunal accepted, as set out in the CQC Report, that Dr Alshafey had a duty to ensure that he was assisted by someone with appropriate skills and experience. It also accepted Mr C's evidence of what a surgical assistant was required to do. The Tribunal also accepted that it had not been established in evidence that in order to undertake the Liposuction Procedure, a trained operating assistant was required to be present.

216. The Tribunal was of the view that if it was mistaken that Dr Alshafey did have a duty to ensure there was a trained operating assistant, it accepted his evidence that the HCA present had the appropriate training to be able to monitor basic clinical signs. It also accepted Mr C's opinion that if the person present was an HCA, she was qualified to undertake the role required.

217. In the absence of any detail of the conversation with the HCA during the inspection, or evidence from the HCA herself with regard to her qualifications and experience, the Tribunal concluded that there was insufficient evidence to establish that Dr Alshafey had breached a duty to have a trained operating assistant present when an HCA was present.

218. The Tribunal found sub-paragraph 6.a.vi.i. not proved.

Sub-paragraph 6.a.vi.ii.

6. On 13 June 2019 you performed liposuction on a patient ('the Liposuction Procedure') and you:

    a. failed to:

        vi. ensure that the:

            ii. patient was not left unattended during the Liposuction Procedure; **Determined and found proved**

219. The Tribunal considered whether Dr Alshafey had failed to ensure that the patient was not left unattended during the Liposuction Procedure.

220. The CQC Report stated:

*'At times during the procedure, both the doctor and practice manager left the operating room without explanation, leaving the patient unattended except for a member of the CQC inspection team who was observing. This meant that nobody was monitoring the fluids being given to the patient….*

*During the procedure the patient was left for periods of time whilst the doctor and HCA left the theatre room. No information was given to the patient as to why they were being left and nothing was said to the inspector present either.'*

221. In her evidence, Ms B said that she had two interactions with Dr Alshafey during the course of the day of the inspection. The first was a formal interview and the second was to provide him with 'high level' feedback once the inspection had concluded.

222. It was Dr Alshafey's evidence that he was called away from the Liposuction Procedure on four separate occasions, that each absence was at least 20 minutes in length that this extended the length of time the Liposuction Procedure took to around five hours. It was Dr Alshafey's evidence that when he was called away by the CQC team, he was unaware of who remained in the room with the patient.

223. The Tribunal had regard to the testimonial from the patient who underwent the Liposuction Procedure. She wrote *'Whilst having my surgery dr.alshafay [sic] was called out of the room by one of the inspectors and [HCA] was also called out of the room by another inspector that's why I was left alone for a few minutes'*.

224. The Tribunal concluded that Dr Alshafey, as the clinician performing the Liposuction Procedure had a duty to ensure that the patient was safe throughout and was not left unattended. On the basis of the patient's own recollection, she had been left unattended at least once.

225. The Tribunal therefore found sub-paragraph 6.a.vi.ii. of the Allegation proved.

<u>Sub-paragraph 6.a.vi.iii.</u>

6. On 13 June 2019 you performed liposuction on a patient ('the Liposuction Procedure') and you:

    a. failed to:

        vi. ensure that the:

            iii. premises in which you performed the Liposuction Procedure were safe; **Determined and found proved**

226. The Tribunal considered whether Dr Alshafey had failed to ensure that the premises in which he performed the Liposuction Procedure were safe.

227. The Tribunal reminded itself of its previous findings that Dr Alshafey had a duty both as the Registered Manager with the CQC and was also the surgeon in charge of carrying out all procedures at the Clinic.

228. The Tribunal had regard to the full CQC Report, the matters set out under Particular 2 above and to the enforcement action that the CQC took immediately following the inspection.

229. The Tribunal concluded that Dr Alshafey had failed to ensure that the premises in which he performed the Liposuction Procedure were safe.

230. The Tribunal found sub-paragraph 6.a.vi.iii. proved.

Sub-paragraph 6.a.vii

6. On 13 June 2019 you performed liposuction on a patient ('the Liposuction Procedure') and you:

    a. failed to:

        vii. notify the patient's General Practitioner about the Liposuction Procedure undertaken; **Not proved**

231. The Tribunal considered whether Dr Alshafey had failed to notify the patient's GP about the Liposuction Procedure undertaken.

232. The Tribunal was mindful that it had been provided with no medical records or other evidence from the patient who underwent the Liposuction Procedure.

233. Mr C was asked during cross-examination what the appropriate action to take would have been if the patient had stated that she did not want her GP to be notified. Mr C said that without patient consent information about the Liposuction Procedure could not be shared with her GP.

234. The Tribunal accepted the evidence of Mr C and the submission of Mr Holl-Allen that to notify the patient's GP against her wishes would have amounted to a breach of confidentiality.

235. The Tribunal received no evidence to demonstrate that the patient had confirmed to Dr Alshafey that she wished for details of the Liposuction Procedure to be shared with her GP. The Tribunal could therefore not conclude that Dr Alshafey had failed to comply with her wishes.

236. The Tribunal found sub-paragraph 6.a.vii. not proved.

Sub-paragraph 6.b.i., ii., and iii.

6. On 13 June 2019 you performed liposuction on a patient ('the Liposuction Procedure') and you:

    b. put the patient at risk of:

        i. an allergic reaction by failing to undertake the action set out at paragraph 6.a.iii.; Not proved

        ii. potentially dangerous drug interactions by failing to undertake the action set out at paragraph 6.a.iii.; Not proved

        iii. unwanted side effects by failing to undertake the action set out at paragraph 6.a.iii.; Not proved

237. The Tribunal received no evidence to suggest that Dr Alshafey had not ascertained information about the liposuction patient's allergies prior to performing the Liposuction Procedure.

238. In the absence of evidence that Dr Alshafey had failed to ascertain information about the patient's allergies either in a preoperative consultation or prior to the Liposuction Procedure commencing, the Tribunal concluded that there was no basis upon which it could find that he had put the patient at risk.

239. The Tribunal found sub-paragraphs 6.b.i., ii., and iii. not proved.

Sub-paragraph 6.b.iv.

6. On 13 June 2019 you performed liposuction on a patient ('the Liposuction Procedure') and you:

    b. put the patient at risk of:

        iv. serious harm by failing to undertake the action set out at paragraphs 6.a.iii.-6.a.v.ii.; Not proved

240. The Tribunal had regard to this sub-paragraph of the Allegation referred to Dr Alshafey's failings in respect of paragraphs 6.a.iii., 6.a.iv (including i. and ii.) and 6.a.v (including i. and ii.) only.

241. The Tribunal had regard to Mr C's supplementary report:

*'3.1 In my opinion a patient undergoing a procedure under local anaesthetic without sedation in June 2019 should have had a checklist performed pre and post operatively. Failure to do so would fall below the standard expected. In my opinion this would fall below but not seriously below the standard expected because the failure to do so did not or was not likely to result in a serious or significant breach of the GMC guidelines or to cause significant harm to the patient.*

*3.2 Failure to perform the swab count falls below but not seriously below the standard expected. Given the nature of the procedure it is impossible for a swab to be left inside the patient as the incisions are so small. In my opinion this would fall below but not seriously below the standard expected because the failure to do so did not or was not likely to result in a serious or significant breach of the GMC guidelines or to cause significant harm to the patient.*

*3.3 Failure to monitor the patient per and postoperatively falls below the standard expected. In my opinion this would fall below but not seriously below the standard expected because the failure to do so did not or was not likely to result in a serious or significant breach of the GMC guidelines or to cause significant harm to the patient.'*

242. The Tribunal was not satisfied that in the circumstances of its findings and Mr C's opinion that Dr Alshafey's failings in respect of these sub-paragraphs fell below, but not seriously below the standard, that having performed the Liposuction Procedure under local anaesthetic and having had, for the majority of the time, an HCA present, that Dr Alshafey had placed the patient at serious risk of harm.

243. The Tribunal found sub-paragraphs 6.b.iv. not proved.

Sub-paragraphs 6.b.v., vi., and vii.

6. On 13 June 2019 you performed liposuction on a patient ('the Liposuction Procedure') and you:

    b. put the patient at risk of:

        v. tachycardia by failing to undertake the action set out at paragraph 6.vi.ii.; Determined and found proved

        vi. lignocaine toxicity by failing to undertake the action set out at paragraph 6.vi.ii.; Determined and found proved

        vii. syncope by failing to undertake the action set out at paragraph 6.vi.ii.. Determined and found proved

244. The Tribunal considered whether Dr Alshafey had put the patient at risk by failing to ensure that she was not left unattended.

245. The Tribunal had regard to Mr C's evidence in his supplementary report:

> *'4.5 Leaving a patient unattended during an operative procedure that involves the administration of large volumes of local anaesthetic solution puts the patient at risk of harm from tachycardia, lignocaine toxicity, syncope. It therefore falls seriously below the standard expected.'*

246. The Tribunal had already concluded that it was Dr Alshafey's duty to ensure the patient was safe and not left unattended throughout the Liposuction Procedure. The Tribunal therefore accepted the evidence of Mr C that in failing to do so, Dr Alshafey had placed the patient at risk of tachycardia, lignocaine toxicity and syncope.

247. The Tribunal found sub-paragraphs 6.b.v., vi., and vii. proved.

## Paragraph 7

### Sub-paragraph 7.b.

7. In the alternative to paragraph 6.a.iii.to 6.a.vii. you failed to record having undertaken the actions as outlined at paragraph:

    b. 6.a.iv.; **Not proved**

248. The Tribunal noted that paragraph 7 of the Allegation was in the alternative. It therefore considered that where sub-paragraphs under paragraph 6 had been found proved, they would consequently be found not proved here.

249. The Tribunal therefore found sub-paragraph of the Allegation 7.b. not proved.

### Sub-paragraph 7.c.

7. In the alternative to paragraph 6.a.iii.to 6.a.vii. you failed to record having undertaken the actions as outlined at paragraph:

    c. 6.a.v.; **Not proved**

250. The Tribunal noted that sub-paragraph 6.a.v. had been admitted and found proved under paragraph 6 of the Allegation.

251. Accordingly, the Tribunal found sub-paragraph 7.c. of the Allegation not proved.

### Sub-paragraph 7.d.

7. In the alternative to paragraph 6.a.iii.to 6.a.vii. you failed to record having undertaken the actions as outlined at paragraph:

    d. 6.a.vii.. **Not proved**

252. The Tribunal considered its findings under sub-paragraph 6.a.vii. of the Allegation. It found that because Dr Alshafey did not have a duty to inform the patient's General Practitioner about the Liposuction Procedure undertaken and did not do so, the fact that he did not record doing so did not amount to a failure.

253. The Tribunal therefore found sub-paragraph of the Allegation 7.d. not proved.

## The Tribunal's Overall Determination on the Facts

254. The Tribunal has determined the facts as follows:

Patient A

1. On 5 November 2018 and 11 December 2018 you conducted preoperative consultations with Patient A and you failed to:

    a. conduct an adequate physical examination of Patient A on 5 November 2018 in that you did not measure and/or assess:
    **Amended under Rule 17(6)**

        i. height; **Admitted and found proved**

        ii. weight; **Admitted and found proved**

        iii. the presence of any abdominal scars; **Not proved**

        iv. the amount of skin excess; **Not proved**

        v. skin laxity; **Not proved**

        vi. the amount of subcutaneous fat; **Not proved**

        vii. abdominal muscle tone; **Admitted and found proved**

        viii. the presence of any divarication; **Admitted and found proved**

        ix. the amount of intra-abdominal fat; **Determined and found proved**

    b. discuss with Patient A:

        i. presenting concerns; **Not proved**

ii. past medical history; **Determined and found proved**

iii. examination; **Not proved**

iv. treatment options; **Determined and found proved**

v. the procedure proposed; **Not proved**

vi. potential:

i. side effects; **Determined and found proved**

ii. risks; **Determined and found proved**

iii. complications; **Determined and found proved**

vii. obstetric history; **Determined and found proved**

viii. abdominal operations; **Determined and found proved**

ix. weight changes. **Determined and found proved**

2. On 5 January 2019 you performed an abdominoplasty combined with liposuction and fat grafts on Patient A ('the Procedure') and:

a. you failed to:

i. undertake adequate training prior to completing the abdominoplasty procedure; **Admitted and found proved**

ii. adequately record who administered the local anaesthetic to Patient A; **Not proved**

iii. perform the:

i. World Health Organisation ('WHO') checklist; **Admitted and found proved**

ii. veno-thrombo embolism assessment; **Admitted and found proved**

iv. ensure:

i. you had supervision from an appropriately trained and accredited surgeon whilst performing the Procedure; **Determined and found proved**

ii. that the premises in which you performed the Procedure were safe; **Determined and found proved**

b. by not having the adequate training in performing the abdominoplasty procedure you put Patient A at risk of:

i. serious harm; **Determined and found proved**

ii. life threatening consequences. **Determined and found proved**

3. On 15 January 2019 you consulted with Patient A and you failed to provide adequate postoperative care, in that you:

a. failed to:

i. detect:

i. skin necrosis; **Not proved**

ii. impending necrosis; **Not proved**

ii. measure Patient A's temperature; **Admitted and found proved**

iii. ensure that the results of Patient A's microbiology were identified; **Admitted and found proved**

iv. establish the cause of Patient A's infection; **Not proved**

v. recognise the potential risk of Patient A's infection developing into necrotising fasciitis; **Determined and found proved**

vi. prescribe appropriate antibiotics; **Not proved**

vii. arrange for Patient A's urgent admission to hospital for:

i. close observation; **Admitted and found proved**

ii. exploration of the wound; **Admitted and found proved**

iii. debridement of the wound; **Admitted and found proved**

viii. arrange for a further review within 48 hours to confirm that Patient A's infection was not worsening; **Determined and found proved**

b. put Patient A at risk of the following by failing to undertake the actions as set out at paragraph 3.a.:

i. severe harm; Determined and found proved

ii. significant morbidity; Determined and found proved

iii. life threatening changes. Determined and found proved

4. In the alternative to paragraphs 1-3 above you failed to record having undertaken the actions as outlined at paragraph:

   a. 1.a.;
   Determined and found prove in respect of sub-paragraphs 1.a.iii., iv., v., and vi
   Not proved in respect of sub-paragraphs 1.a.i, ii., vii., viii., and ix.

   b. 1.b.;
   Determined and found proved in respect of sub-paragraphs 1.b.i. and v.
   Not proved in respect of sub-paragraphs 1.b.ii., iii., iv., vi., vii., viii., and ix.

   c. 2.a.iii.; Not proved

   d. ~~2.a.iv.2.~~ 2.a.iv.1.; Not proved
   Amended under Rule 17(6)

   e. 3.a.. Not proved

5. You failed to record any postoperative instructions. Not proved

Liposuction Procedure

6. On 13 June 2019 you performed liposuction on a patient ('the Liposuction Procedure') and you:

   a. failed to:

      i. hold an up to date qualification in intermediate or advanced life support; Determined and found proved
      Amended under Rule 17(6)

      ii. have a sepsis policy in place; Admitted and found proved

      iii. ascertain preoperatively if the patient had any known allergies; Not proved

      iv. perform:

         i. the WHO 'Five Steps to Safer Surgery' checklist preoperatively and / or postoperatively; Admitted and found proved

ii. a swab count during and / or at the end of the Liposuction Procedure; **Admitted and found proved**

v. monitor both intraoperatively and / or postoperatively the:

i. pulse rate; **Admitted and found proved**

ii. blood pressure; **Admitted and found proved**

vi. ensure that the:

i. staff assisting with the Liposuction Procedure were trained operating assistants who could identify basic clinical signs; **Not proved**

ii. patient was not left unattended during the Liposuction Procedure; **Determined and found proved**

iii. premises in which you performed the Liposuction Procedure were safe; **Determined and found proved**

iv. documentation and / or prescriptions for the medications provided to the patient was adequate, including details of analgesia given before, during and after the procedure; **Admitted and found proved**

vii. notify the patient's General Practitioner about the Liposuction Procedure undertaken; **Not proved**

b. put the patient at risk of:

i. an allergic reaction by failing to undertake the action set out at paragraph 6.a.iii.; **Not proved**

ii. potentially dangerous drug interactions by failing to undertake the action set out at paragraph 6.a.iii.; **Not proved**

iii. unwanted side effects by failing to undertake the action set out at paragraph 6.a.iii.; **Not proved**

iv. serious harm by failing to undertake the action set out at paragraphs 6.a.iii.-6.a.v.ii.; **Not proved**

v. tachycardia by failing to undertake the action set out at paragraph 6.vi.ii.; **Determined and found proved**

vi. lignocaine toxicity by failing to undertake the action set out at paragraph 6.vi.ii.; **Determined and found proved**

vii. syncope by failing to undertake the action set out at paragraph 6.vi.ii.. **Determined and found proved**

7. In the alternative to paragraph 6.a.iii.to 6.a.vii. you failed to record having undertaken the actions as outlined at paragraph:

   a. 6.a.iii.; **Admitted and found proved**

   b. 6.a.iv.; **Not proved**

   c. 6.a.v.; **Not proved**

   d. 6.a.vii.. **Not 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 -** 19/01/2022

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 Alshafey'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 received further documentary evidence on behalf of Dr Alshafey, this included but was not limited to:

- Dr Alshafey's statement of personal reflections, undated;
- Continuing Professional Development (CPD) certificates:
  - Recognition and Management of Sepsis in Primary Care, dated 14 February 2020;
  - Primary Care Module, dated 18 February 2020;
- Draft Consultation Form prepared by Dr Alshafey;
- Dr Alshafey's proposed Sepsis Recognition Policy and Care of Deteriorating Patients Policy;
- Two testimonials provided in support of Dr Alshafey.

## Submissions

On behalf of the GMC

3. On behalf of the GMC, Ms Tighe submitted that the facts found proved against Dr Alshafey amount to serious misconduct, and that Dr Alshafey's fitness to practise is currently impaired by reason of that misconduct. Throughout her submissions, Ms Tighe referred the Tribunal to the relevant principles and authorities regarding consideration of misconduct and impairment.

4. Ms Tighe reminded the Tribunal of its own findings and of the expert evidence of Mr C, who had set out in his reports which of Dr Alshafey's actions (or inactions) had been acceptable, below or seriously below the standard expected. Ms Tighe submitted that Dr Alshafey had breached paragraphs 14 and 15 of Good Medical Practice (2013) (GMP) (set out below). She submitted that Dr Alshafey's actions amounted to a significant departure from GMP. On the basis of the expert evidence, the Tribunal's own findings and his breaches of GMP, Ms Tighe invited the Tribunal to find that Dr Alshafey's actions amounted to serious misconduct.

5. In respect of impairment, Ms Tighe referred the Tribunal to the test set out by Dame Janet Smith in the Fifth Shipman Report as adopted by the High Court in *CHRE v NMC and Grant* [2011] EWHC 927 (Admin) ('*Grant*'). She submitted that Dr Alshafey's conduct at the time engaged the first three limbs of the *Grant* test in that he had put patients at unwarranted risk of harm, had brought the medical profession into disrepute and had breached one of the fundamental tenets of the profession.

6. Ms Tighe made submissions with reference to Dr Alshafey's statements and remediation bundle as to his level of insight, remorse and remediation. Ms Tighe submitted that Dr Alshafey had yet to develop full insight into his misconduct in relation to both Patient A and the Liposuction Procedure. In terms of remediation, she submitted that Dr Alshafey has not yet fully remediated his misconduct. On the basis on his developing insight and incomplete remediation, Ms Tighe submitted that there remains a risk of repetition in Dr Alshafey's case.

7. Ms Tighe submitted that even if the Tribunal concluded that Dr Alshafey had developed complete insight and fully remediated his misconduct, a finding of impairment would still be required in order to uphold the second and third limbs of the overarching objective. Ms Tighe invited the Tribunal to conclude that Dr Alshafey's fitness to practise is impaired by reason of his misconduct.

On behalf of Dr Alshafey

8. On behalf of Dr Alshafey, Mr Holl-Allen KC confirmed that he would be making no positive submissions on behalf of Dr Alshafey in respect of either, his actions amounting to

serious professional misconduct, or his fitness to practise being currently impaired by that misconduct. He informed the Tribunal that Dr Alshafey accepted the findings of the Tribunal in full. Mr Holl-Allen submitted that it was for the Tribunal alone, using its independent judgement, to determine both misconduct and impairment, he submitted that he was neutral on both.

9. Mr Holl-Allen agreed with Ms Tighe's summary of the relevant legal principles and accepted that paragraphs 14 and 15 of GMP were engaged. He also accepted that it was appropriate in its consideration of misconduct for the Tribunal to consider the opinion of Mr C, who, Mr Holl-Allen submitted, was a fair and balanced expert. Mr Holl-Allen reminded the Tribunal that at the time Mr C expressed his expert opinion, he did not know which elements of the case were to be admitted or which would be found proved by the Tribunal.

10. Mr Holl-Allen submitted that Dr Alshafey was profoundly affected by Patient A's case. He reminded the Tribunal that he had reported himself to the GMC within days of performing what would be his only abdominoplasty procedure on Patient A. Mr Holl-Allen referred the Tribunal to Dr Alshafey's reflections. In particular, he drew the Tribunal's attention to Dr Alshafey's indication that he has no intention to return to performing abdominoplasty procedures in his future career.

11. Mr Holl-Allen reminded the Tribunal of Dr Alshafey's significant admissions. Mr Holl-Allen reminded the Tribunal that it had concluded that Dr Alshafey had given an open and honest account of events, even where it revealed failings in his care and management. He submitted that Dr Alshafey has sought to address the findings of the Tribunal, including those that went beyond his admissions, in his reflections and invited the Tribunal to consider them carefully. He referred the Tribunal to Dr Alshafey's reflection that he came to make the serious error not to arrange Patient A's urgent admission to hospital because he was overly focused on how he could address a problem that was of his own making, rather than considering how it could be addressed by others, in the best interests of the patient.

12. Mr Holl-Allen asked the Tribunal to consider the context in which Dr Alshafey set out why he decided he wanted to offer abdominoplasty at his clinic. He submitted that the abdominoplasty performed on Patient A was done out of a genuine desire to provide an additional service to his patients, not to take advantage of them.

13. Mr Holl-Allen referred the Tribunal to Dr Alshafey's reflection that it is extremely difficult to be both lead operating surgeon and the registered manager of a private clinic as Dr Alshafey was. Mr Holl-Allen stated that Dr Alshafey has no intention of combining those roles again in the future. In respect of the Liposuction Procedure, Mr Holl-Allen reminded the Tribunal of its findings and Mr C's expert opinion. Mr Holl-Allen submitted that Dr Alshafey has expressly recognised in his reflections that having to deal with the CQC inspection on the day of the Liposuction Procedure was not an excuse for failing to ensure the patient was not left unattended, but it did provide some context.

14. Mr Holl-Allen submitted that Dr Alshafey has insight into the deficiencies in his care, and as a result of that insight has expressed genuine remorse for the suffering of Patient A that were a result of his own acts and omissions. He referred the Tribunal to Dr Alshafey's CPD and submitted that the courses completed by Dr Alshafey have fed into his learning and how he proposes to proceed in his future career. Mr Holl-Allen explained Dr Alshafey's intentions and future plans, and drew the Tribunal's attention to the draft consultation form Dr Alshafey has produced in the knowledge that cosmetic procedures that are elective and not therapeutic require a particularly high standard of care. If possible, Dr Alshafey hopes to return to working in the NHS in Obstetrics and Gynaecology while continuing to practise privately performing liposuction part time. Mr Holl-Allen also referred the Tribunal to the two testimonials provided in support of Dr Alshafey.

15. Mr Holl-Allen submitted that Dr Alshafey acknowledges that the Tribunal found significant deficiencies in both his treatment of Patient A, and the circumstances of the Liposuction Procedure. He submitted that Dr Alshafey has not sought to persuade the Tribunal that his actions did not amount to serious professional misconduct or that his fitness to practise is not currently impaired by that misconduct. During its deliberations on misconduct and impairment, Mr Holl-Allen requested that the Tribunal have regard to the mitigating factors and Dr Alshafey's open and honest attitude which has continued since he first reported himself to the GMC.

## The Relevant Legal Principles

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

17. 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 and that the misconduct was serious. Second, whether the finding of that serious misconduct could lead to a finding of impairment.

18. In considering whether Dr Alshafey' fitness to practise is currently impaired, the Tribunal to applied the first three limbs of the test as set out by Dame Janet Smith in the Fifth Shipman Report as adopted by the High Court in *CHRE v NMC and Grant* [2011] EWHC 927 (Admin) ('*Grant*' ):

> *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*

*d. …*

19. The Tribunal must determine whether Dr Alshafey's fitness to practise is impaired today, taking 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 any likelihood of repetition.

## The Tribunal's Determination on Impairment

### Misconduct

20. The Tribunal considered its findings on each paragraph of the Allegation in respect of first, whether they amounted to misconduct, and second whether that misconduct was serious.

Patient A

Paragraph 1.a.

21. The Tribunal first considered whether Dr Alshafey's failings in respect of the adequacy of the physical examination performed on Patient A on 5 November 2018 amounted to misconduct.

22. The Tribunal had regard to its own findings and reminded itself that Mr C had accepted that if Dr Alshafey had performed the examination as it suggested he had in the consultation letter to Patient A and no more, his physical examination of Patient A had been adequate.

23. The Tribunal had previously found that Dr Alshafey had failed to measure or assess the amount of intra-abdominal fat during his consultation with Patient A. However, the Tribunal was satisfied that, even in the absence of this part of the examination, it did not amount to misconduct because it accepted Mr C's evidence that the physical consultation was adequate.

24. The Tribunal therefore found that Dr Alshafey's actions in respect of paragraph 1.a. of the Allegation were satisfactory and therefore did not amount to misconduct.

Paragraph 1.b.

25. The Tribunal considered whether Dr Alshafey's failings in respect of his discussion with Patient A amounted to misconduct.

26. The Tribunal found that while he had asked Patient A a number of closed questions relating to her medical history, there were a number of relevant matters that had not been discussed including Patient A's obstetric and psychiatric history, as well as any abdominal operations. Further, it found that Dr Alshafey had failed to discuss treatment options with Patient A, as well as the potential side effects, risks and complications of abdominoplasty. Providing Patient A with written information did not amount to a discussion.

27. Mr C's expert opinion was that failure to undertake an adequate preoperative consultation, which the Tribunal was satisfied would include a discussion with Patient A about all the matters set out above, was seriously below the standard expected.

28. In particular, the Tribunal was concerned that in not discussing Patient A's weight changes or her psychiatric history, Dr Alshafey did not obtain relevant information that could have had an impact on his assessment of her suitability for abdominoplasty surgery.

29. The Tribunal concluded that Dr Alshafey's failings in respect of his discussions with Patient A amounted to misconduct. In light of Mr C's expert opinion that this fell seriously below the standard expected, the Tribunal was satisfied that Dr Alshafey's misconduct was serious in respect of these failings.

Paragraph 2.a.

30. The Tribunal then considered whether Dr Alshafey's failings in respect of the Procedure on 5 January 2019 amounted to misconduct.

31. The Tribunal found that failing to undertake adequate training prior to completing the Procedure was a significant failing that amounted to misconduct that was serious.

32. The Tribunal accepted Mr C's expert evidence that failing to perform the WHO checklist or a veno-thrombo embolism assessment on Patient A was seriously below the standard expected. The Tribunal found that these failings also amounted to misconduct that was serious.

33. In respect of Dr Alshafey's failure to ensure he had supervision from an appropriately trained and accredited surgeon whilst performing the Procedure. In his reflections he said *'What makes me sad is that it was easy to arrange for a senior colleague to assist me in my first 20 patients to make sure I was well supported with confidence and competence to do it, and I missed that'*. The Tribunal accepted that this failing was not separate to Dr Alshafey's failure to undertake adequate training before completing the Procedure. It found that it was a reflection of Dr Alshafey's lack of insight into what was required to safely undertake abdominoplasty surgery that he proceeded without supervision.

34. The Tribunal found previously that, in line with Dr Alshafey's evidence that there were not any material differences in the premises between January and June 2019, that the CQC Report was relevant considering the safety of the premises. As such it concluded that the premises in which Dr Alshafey performed the Procedure were not safe. Dr Alshafey had a clear duty to ensure the premises were safe, clean and suitable for performing abdominoplasties as the Registered Manager of the premises and as the lead clinician. Having failed to do so, in line with Mr C's opinion that *'Failure to ensure that the premises in which the operation was performed were of an adequate safety level'* fell seriously below the expected standard, the Tribunal found that Dr Alshafey's failing in respect of the premises amounted to misconduct that was serious.

Paragraph 2.b.

35. The Tribunal was satisfied that by not having adequate training before performing the Procedure and putting Patient A at risk of serious harm and life threatening consequences amounted to misconduct that was serious.

Paragraph 3.a. and 3.b.

36. In respect of Patient A's postoperative care, Mr C found that her care was inadequate and the Tribunal accepted his opinion that Dr Alshafey's care fell seriously below the standard expected.

37. The Tribunal was particularly concerned that having decided not to arrange for Patient A's urgent admission to hospital to assess her obvious serious wound infection, Dr Alshafey made no arrangements to review Patient A on his own premises prior to a debridement planned for five days after the consultation of 15 January 2019. This was in circumstances where Dr Alshafey accepted that it was clear that the condition of her wound was deteriorating. The Tribunal found that Dr Alshafey failed to provide adequate postoperative care to Patient A.

38. The Tribunal accepted Mr C's evidence and found that Dr Alshafey's failings in respect of Patient A's postoperative care were seriously below the standard of care expected and found that Dr Alshafey put Patient A at risk of severe harm, significant morbidity and life threatening changes. It found that his failings therefore amounted to misconduct that was serious.

Paragraph 4

39. In respect of Dr Alshafey's failings in respect of his record keeping, the Tribunal had regard to Mr C's expert opinion. Mr C was of the view that Dr Alshafey's record keeping was below, but not seriously below the expected standard.

40. Accordingly, the Tribunal accepted that Dr Alshafey's failings in record keeping amounted to misconduct, but the misconduct was not serious.

41. The Tribunal noted that Dr Alshafey had referred to completing a 'Documentation & Record Keeping Level 2 Course' in his reflections. Dr Alshafey referred the Tribunal to the draft consultation form which he said resulted from the course. The Tribunal did so but was mindful that it had not been provided with any details about this course or a certificate.

Liposuction Procedure

Paragraphs 6.a. and 6.b.

42. The Tribunal accepted Mr C's expert evidence that failing to hold an up to date intermediate or advanced life support qualification in line with the Academy of Medical Colleges requirement fell below, but not seriously below the standards expected.

43. The Tribunal reminded itself that while Dr Alshafey may have basic life support knowledge, the CQC had identified that some of the contents of the resuscitation 'box' were out of date which would have impeded any attempts to provide life support to a patient should an issue have arisen.

44. The Tribunal also noted that despite the time elapsed since its determination on the facts was handed down, and having known the requirements of the Academy of Medical Colleges for some time, Dr Alshafey appeared not to have completed an intermediate or advanced life support qualification.

45. In view of the expert evidence, the Tribunal found that this failing therefore amounted to misconduct, but did not amount to serious misconduct.

46. The Tribunal has already found that the premises as a whole were unsafe. However, the Tribunal did not find that there was sufficient material from which it could conclude that Dr Alshafey's admitted failure to have a sepsis policy in place fell seriously below the standard required. Accordingly, the Tribunal did not make a finding that this failing amounted to misconduct that was serious.

47. The Tribunal accepted Mr C's evidence that Dr Alshafey's admitted failure to perform the WHO checklist or a swab count was below but not seriously below the standard expected given the nature of the procedure. Mr C also concluded that failing to monitor the patient's pulse rate and blood pressure intraoperatively and/or postoperatively fell below but not seriously below the standard expected. Accordingly, the Tribunal did not conclude that Dr Alshafey's failures amounted to misconduct that was serious.

48. In respect of the Liposuction Procedure, Mr C concluded that *'Leaving a patient unattended during an operative procedure that involves the administration of large volumes of local anaesthetic solution puts the patient at risk of harm from tachycardia, lignocaine*

*toxicity, syncope. It therefore falls seriously below the standard expected.'* The Tribunal was of the view that failing to ensure a patient was not left unattended given the risks involved in the Liposuction Procedure amounted to misconduct that was serious.

49. The Tribunal concluded that Dr Alshafey's failure to ensure the premises in which he performed the Liposuction Procedure were safe amounted to misconduct that was serious.

50. By failing to ensure the patient was not left unattended and failing to ensure the premises were safe, Dr Alshafey increased the patient's risk of harm.

Good Medical Practice

51. Having considered its own findings and the expert evidence in detail, the Tribunal considered whether, taken as a whole, Dr Alshafey's failings amounted to any breaches of GMP or the 'Guidance for doctors who offer cosmetic interventions' (2016) ('the Guidance').

52. The Tribunal noted that it was agreed between the parties that paragraphs 14 and 15 of GMP were engaged and the Tribunal accepted that:

> '***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.'*

53. The Tribunal also considered the paragraphs 7 and 8 of GMP were engaged:

> *'**7** You must be competent in all aspects of your work, including management, research and teaching.*
>
> ***8*** *You must keep your professional knowledge and skills up to date.'*

54. The Tribunal found that paragraph 13 of the Guidance was also engaged:

> *'13 You should be satisfied that the environment for practice is safe, suitably equipped and staffed and complies with any relevant regulatory requirements.'*

55. It also had regard to paragraph 28 of the '*Leadership and management for all doctors'* guidance which was set out in an Annex to the Guidance and states:

> *'28 If you have a management role or responsibility, you must make sure that systems are in place to give early warning of any failure, or potential failure, in the clinical performance of individuals or teams. These should include systems for conducting audits and considering patient feedback. You must make sure that any such failure is dealt with quickly and effectively.'*

56. In respect of Patient A, Dr Alshafey was not sufficiently trained to be competent to perform an abdominoplasty. As such he failed to work within the limits of his competence and failed to adequately assess the risk Patient A faced when it became clear that she had developed a serious wound infection. Dr Alshafey did not arrange for Patient A's urgent admission to hospital, nor did he arrange a follow up appointment in 48 hours to ensure her infection had not worsened further. He did not serve Patient A's needs and placed her at a higher risk of harm.

57. In both cases, Dr Alshafey failed to ensure the premises where he was performing the procedures were safe, therefore not meeting his duty as either the Registered Manager of the premises or the lead surgeon. He did not have suitable resuscitation equipment and medication, which again was a serious cause for concern for both the CQC and the Tribunal. In addition, during the Liposuction Procedure, Dr Alshafey failed to ensure that the patient was not left unattended and therefore increased her risk of harm.

58. The Tribunal was of the view that its individual findings of serious misconduct, taken together, amounted to significant breaches of GMP and the Guidance that was available to Dr Alshafey at the time.

59. Taken as a whole, the Tribunal concluded that Dr Alshafey had failed Patient A and the Liposuction Procedure patient risk at all stages of their treatment. The Tribunal concluded that fellow professionals would consider Dr Alshafey's conduct in both cases to be deplorable. Accordingly, the Tribunal concluded that Dr Alshafey's failings fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct that was serious.

## Impairment

60. The Tribunal having found that the facts found proved amounted to misconduct, went on to consider whether, as a result, Dr Alshafey's fitness to practise is currently impaired.

61. The Tribunal was satisfied that Dr Alshafey's clinical failings were potentially remediable. Nevertheless, the Tribunal found that the repeated errors of judgement that underlay many of those failings, would be very difficult to remediate.

62. In considering impairment, the Tribunal applied the first three limbs of the test set out in *Grant*.

63. The Tribunal concluded that Dr Alshafey's actions had clearly in the past placed both patients, most seriously Patient A, at unwarranted risk of harm.

64. In considering whether Dr Alshafey was liable to place patients at unwarranted risk of harm in the future, the Tribunal considered the level of insight and remediation he had achieved.

65. The Tribunal had regard to Dr Alshafey's statement of personal reflections. It considered that Dr Alshafey had expressed genuine remorse and did have some insight into his misconduct, he attempted to explain why he acted as he did and set out the impact of his failings on Patient A. Dr Alshafey set out all the reasons why he should not perform another abdominoplasty, which he described as both *'emotional'* and *'rational'*. However, Dr Alshafey did not yet appear to have adequately reflected on and understood why he believed it was appropriate for him to undertake an abdominoplasty procedure without appropriate training.

66. The Tribunal was not persuaded by Dr Alshafey's assertion that his transferable skills from performing caesarean sections gave him a sufficient reason to believe he could begin training to perform abdominoplasties. Dr Alshafey's enquiries for support and training for abdominoplasty in the UK were rebuffed. However, he did not pause to consider why the NHS did not see it to be appropriate to assist in the training of a doctor who had never achieved a sufficient level of competency in Obstetrics and Gynaecology to perform unsupervised major surgery, had not undertaken any open surgical procedures for several years, and had no General Surgical training. Dr Alshafey simply continued with his private book-based research and identified two days of training he could undertake overseas. Beyond seeking to assure the Tribunal that he would not undertake another abdominoplasty procedure or any other procedure which he was not trained to do, Dr Alshafey did not set out how he would ensure that the failings identified in his practice, and in particular his serious errors of judgement, would not be repeated.

67. Further, the Tribunal found that Dr Alshafey had yet to appreciate the seriousness of, and his responsibility as a surgeon for his failings in respect of the safety of the premises he used to perform both surgeries. Dr Alshafey had worked in surgical environments in the NHS while in Obstetrics and Gynaecology, he would have been aware of the hygiene, safety and infection control measures required to ensure premises are safe for all procedures. He did not explain why he failed to use this knowledge to ensure his own premises were safe and compliant with all relevant standards.

68. The Tribunal concluded that Dr Alshafey had yet to demonstrate sufficient insight into the breadth of his serious failings.

69. In respect of his remediation, the Tribunal was concerned that not only was the evidenced CPD (certificates provided) completed in February 2020, almost two years ago, it was sparse and not specific to Dr Alshafey's failings, current practice or the practice he aspires to in the future. No additional evidence had been provided in relation to the courses Dr Alshafey referred to his reflections aside from the 'Recognition and Management of Sepsis in Primary Care'. Completing primary care specific modules as a clinician with a private practice in liposuction and no apparent desire to work in primary care, did not appear to the Tribunal to be sufficiently focused on Dr Alshafey's misconduct.

70. Further, Dr Alshafey expressed an intention of returning to the NHS in Obstetrics and Gynaecology. However, neither his reflections, nor his CPD demonstrate a commitment to seeking to refresh his skills relevant to returning to that speciality. His CPD, as well as the draft consultation form and the proposed 'Sepsis Recognition' and 'Care of Deteriorating Patients' policies focus on matters more relevant to his private practice, which in his reflections, he suggests would become secondary to working in the NHS. The Tribunal was therefore of the view that while Dr Alshafey had attempted some remediation, that remediation was not focused on that what he said were his future career goals, nor was it remediation that was specifically targeted to address the most serious failings identified.

71. In light of these conclusions, the Tribunal could not be satisfied that Dr Alshafey was highly unlikely to repeat his misconduct and place a patient at unwarranted risk of harm again. It concluded that there remained a risk of repetition.

72. The Tribunal went on to consider whether Dr Alshafey's misconduct was liable to bring the profession into disrepute. The Tribunal had regard to its findings on misconduct, insight and remediation. It found that the medical profession is brought into disrepute if patients are treated by doctors who perform surgery without adequate training in unsafe premises. It concluded that Dr Alshafey's actions in the past had clearly brought the profession into disrepute and having failed to sufficiently address his misconduct, Dr Alshafey risked damaging the reputation of the profession in the future.

73. The Tribunal concluded that Dr Alshafey had breached fundamental tenets of the profession in the following ways:

a) He failed to provide an adequate standard of care by carrying out surgery without adequate training and skill;
b) He did not recognise the limits of his own competency by carrying out the abdominoplasty on Patient A;
c) He did not make the care of patients his first concern when he failed to refer Patient A to hospital despite her worsening infection;
d) He placed his patients at risk by failing to recognise that his premises were unsafe.

74. The Tribunal also concluded that Dr Alshafey was liable to breach fundamental tenets of the profession in the future because of his inadequate insight and remediation.

75. Taking all of the above into account, the Tribunal considered whether a finding of impairment was required to uphold the overarching objective. It concluded that having not demonstrated sufficient insight or remediation, and there remaining a risk to patient safety, a finding of impairment was required in order to uphold all three limbs of the overarching objective.

76. The Tribunal has already set out why Dr Alshafey presents a continuing risk to patients. It also found that a finding of impairment was required 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 because of the gravity and persistence of his failings.

77. The Tribunal has therefore determined that Dr Alshafey's fitness to practise is impaired by reason of misconduct.

## Determination on Sanction - 22/09/2022

1. Having determined that Dr Alshafey'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 Outcome of Applications Made during the Sanction Stage

2. The Tribunal accepted the GMC's submissions, made pursuant to Rules 15 and 40 of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), that notice of this reconvened hearing had properly been served on Dr Alshafey, and granted its application, made pursuant to Rule 31 of the Rules, that this hearing should proceed in his absence. The Tribunal's full decision on these applications is included at Annex E.

## The Evidence

3. The Tribunal has taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction. No further evidence was adduced at this stage of proceedings.

## Submissions

4. On behalf of the GMC, Ms Tighe identified mitigating factors (which the Tribunal accepted and set out below) and submitted that there were no additional aggravating factors beyond those inherent in the Tribunal's findings of fact.

5. She submitted that there were no exceptional circumstances in this case to warrant the Tribunal taking no action. She submitted that undertakings had not been offered or agreed. In respect of conditions, Ms Tighe reminded the Tribunal that many aspects of Dr Alshafey's practice had been found to be seriously below the standard expected. She acknowledged that Dr Alshafey has shown some insight and submitted this was a case where a period of supervision and retraining could be appropriate. However, she submitted that given the serious nature of Dr Alshafey's misconduct, conditions would not be the proportionate sanction in this case.

6. Ms Tighe referred the Tribunal to paragraphs 97a, e, f and g of the Sanctions Guidance (2020) ('the SG'), set out below. She submitted that Dr Alshafey's misconduct amounted to a serious breach of GMP but that his actions were not fundamentally incompatible with continued registration. In respect of erasure, Ms Tighe identified paragraphs 109a, b and c of the SG. Accordingly, she submitted that the GMC's position was that erasure would not be appropriate nor proportionate in the circumstances of this case.

## The Tribunal's Determination on Sanction

7. 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 and borne in mind the over-arching objective.

8. The Tribunal reminded itself that the main reason for imposing any sanction is to protect the public and that sanctions are not imposed to punish or discipline doctors, even though they may have a punitive effect. Throughout its deliberations, the Tribunal has applied the principle of proportionality, balancing Dr Alshafey's interests with the public interest. It also reminded itself that "*the reputation of the profession as a whole is more important than the interests of any individual doctor.*"

### Aggravating and Mitigating Factors

9. 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 Dr Alshafey's registration, the Tribunal considered and balanced the aggravating and mitigating factors in this case.

10. The Tribunal was mindful of the breaches to fundamental tenets of the profession it had identified in its determination on impairment. The Tribunal has been mindful of the danger of double counting the matters found proved against Dr Alshafey. Nevertheless, the Tribunal found that the following matters, taken together, did make Dr Alshafey's misconduct more serious and pointed to towards a more restrictive sanction.

- Dr Alshafey has been unable to articulate in his written submissions, the rationale behind his decision-making that led him to breach four fundamental tenets of the profession, putting patients at risk of harm;
- Having disengaged from proceedings, Dr Alshafey has provided no evidence of further reflection, insight or remediation that could explain his previous behaviour and poor judgement in order to reassure the Tribunal that the risk of repetition has been sufficiently reduced;
- Dr Alshafey's misconduct could not be characterised as an isolated incident as he acknowledged that his premises were unsafe for over a year and his inadequate treatment of Patient A continued for over 2 months.

11. The Tribunal identified the mitigating factors to be:

- Dr Alshafey accepted that what he did was wrong, he has developed some insight, and has reflected on, and shown genuine remorse for, his actions;
- Dr Alshafey's misconduct occurred over three years ago, and there was no evidence before the Tribunal that he had repeated any similar misconduct.

12. The Tribunal considered the aggravating and mitigating factors throughout its deliberations on what the appropriate and proportionate sanction to impose would be, if any. For the reasons set out below, the Tribunal found that the aggravating features in this case outweighed the mitigating factors. The Tribunal considered each sanction in ascending order of severity, starting with the least restrictive.

## No action

13. 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 are no exceptional circumstances in this case and that, given the seriousness of its findings, it would not be sufficient, proportionate, nor in the public interest to conclude this case by taking no action.

## Conditions

14. The Tribunal next considered whether to impose conditions on Dr Alshafey's registration. The Tribunal accepted that conditions are appropriate and workable in certain circumstances including where a doctor has been open and honest and has shown insight. It also noted that conditions may also 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.

15. The Tribunal acknowledged that some of the failings identified in Dr Alshafey's practice were clinical failings that had the potential to be remedied with a period of robust

support, supervision, and retraining. The Tribunal accepted that if the misconduct found against Dr Alshafey had been limited to failings in clinical competence, it would have been possible to formulate appropriate, workable and measurable conditions. However, the Tribunal found that Dr Alshafey had displayed a disturbing lack of judgement in his decision-making, despite a number of years post qualification experience:

- He had decided to practise well beyond the limits of his own competency and experience in undertaking an abdominoplasty without adequate training, skill or supervision;
- He had failed to implement appropriate post-operative actions in managing Patient A's infected wound and his inaction caused delay which risked and led to serious consequences;
- He had operated in and overseen premises that were unsafe. He only acknowledged there was an issue with the premises and equipment when it was identified by the CQC;
- He had not demonstrated an understanding of why he took such potentially disastrous decisions in a way that might reassure the Tribunal that he understood how to avoid repetition.

16. In the Tribunal's view, such failures of judgement and decision-making would be much more difficult to guard against in the formulation of conditions. Dr Alshafey had demonstrated through his actions and in evidence that he had a concerning lack of insight into the limits of his own clinical competencies and transferable skills. He had sought training from the NHS to allow him to perform abdominoplasties and had been told such training would not be possible. Instead of acknowledging that this suggested it was not appropriate for him to perform such a high-risk surgery in light of his lack of relevant surgical training and experience, he identified a two day training overseas and went on to perform the abdominoplasty unsupervised, in circumstances where he acknowledged that he had never previously carried out major surgery unsupervised. Further, he suggested that he would return to practising in Obstetrics and Gynaecology despite having not practised in the field for seven years. In light of Dr Alshafey's poor decision-making and judgement, as well as his disengagement from these proceedings and his regulator, the Tribunal could not be satisfied that he would comply with any conditions imposed.

17. The Tribunal concluded that Dr Alshafey's actions arose from a wide ranging and deep-seated disregard for the standards expected of him as a registered medical practitioner and as the Registered Manager of the premises the CQC and the Tribunal had found to be unsafe. In these circumstances, the Tribunal determined that imposing conditions on Dr Alshafey's registration would not mark the seriousness with which it viewed his misconduct. It decided that to impose conditions in such circumstances would not promote or maintain public confidence in the medical profession.

## Suspension

18. The Tribunal went on to consider whether to impose a period of suspension on Dr Alshafey's registration. The Tribunal accepted that suspension does have a deterrent effect and could be used to send a signal to Dr Alshafey, the profession, and the public about what is regarded as behaviour unbefitting a registered doctor. The Tribunal was mindful that 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.

19. It was the GMC's submission that a period of suspension was the appropriate and proportionate sanction in this case. The Tribunal had regard to the paragraphs of the SG that Ms Tighe had referred to:

> *'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…*
> >
> > *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.'*

20. The Tribunal also had regard to paragraphs 129 and 130 of the SG, relating to cases where a doctor's misconduct arises from an unacceptable level of treatment or care:

> *'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' (Good medical practice, paragraph 1).*
>
> *130 A particularly important consideration in these cases is whether a doctor has developed, or has the potential to develop, insight into these failures. Where insight is not evident, it is likely that conditions on registration or suspension may not be appropriate or sufficient.'*

21. The Tribunal reminded itself that it had found Dr Alshafey's misconduct engaged all three limbs of the overarching objective. It had also found that Dr Alshafey had expressed genuine remorse and knew that what he had done was wrong. However, his insight was limited as he had failed to explain why his judgement had been so impaired as to believe it safe for him to undertake a procedure for which he had entirely inadequate training and experience and to conduct his practice in unsafe premises, putting patients at risk of serious harm and life-threatening consequences.

22. In determining whether suspension was the appropriate, proportionate and least restrictive action to take against Dr Alshafey's registration, the Tribunal was required to considered whether his actions were fundamentally incompatible with continued registration. To do so, the Tribunal considered first whether the misconduct could be remediated successfully and whether Dr Alshafey could remediate for it.

23. The Tribunal had already determined that the issues of clinical competency, including patient consultation and treating patients post-operatively, could in principle be remediated by a period of supervision and appropriate, robust retraining. There was no evidence that Dr Alshafey's clinical competence had previously been a cause of concern. However, the Tribunal had concerns that the repeated errors of judgement that underlay many of those failings would be very difficult to remediate in the circumstances of this case where Dr Alshafey had practised so far outside the limits of his own competency and experience.

24. In terms of Dr Alshafey's own capacity to remediate for his misconduct, the Tribunal was of the view that this was primarily dependent on his engagement. Given his previous participation in these proceedings, the Tribunal accepted that, if he engaged, Dr Alshafey had the potential to respond positively to training, supervision and would likely undertake relevant CPD. However, Dr Alshafey has now disengaged from both these proceedings and his regulator. The Tribunal cannot therefore be satisfied that he would, or could, currently engage in appropriate training to remediate for this misconduct.

25. Further, the Tribunal was concerned that his disengagement could signal a further disregard for the frameworks which are in place to protect patients. He had previously ignored the training framework and advice given to him about the training requirements for surgeons in the UK before they undertake such high-risk surgeries as abdominoplasty; he had failed to realise the need to ensure high standards of hygiene and basic requirements for emergency care in his premises; and he had failed to adhere to the care pathways that exist to treat patients with post-operative infections effectively and promptly. He believed that he could conduct an abdominoplasty and provide an adequate level of post operative care, having read books and attended a two day training course.

26. The Tribunal found that it could not be satisfied that Dr Alshafey would successfully remediate for his misconduct. In view of his limited insight set out in his written submission, and there being no evidence of any more recent remediation or any evidence to explain its absence, the Tribunal determined that there remained an ongoing risk of repetition arising

from Dr Alshafey's failings in judgement and decision-making and his apparent disregard for the processes and procedures in place to protect patients.

27. The Tribunal considered whether a period of suspension would be sufficiently restrictive to promote and maintain public confidence in the medical profession and standards of conduct for the profession. The Tribunal has already decided that Dr Alshafey's actions had brought the profession into disrepute and that there was an ongoing risk that he could do so again in the future. The Tribunal considered that a patient visiting a doctor has a right to expect that their doctor has the relevant knowledge, skills and experience to treat them safely, that their doctor undertakes ongoing training, that they will not be harmed and that the premises in which they are treated are safe and equipped to deal with complications should they arise. This was not the case for the patients identified to the Tribunal.

28. The Tribunal was mindful that clinicians need to follow the guidelines and regulation in place to ensure all safeguards are in place to protect patients. This applies equally to private practice. Patients and the public need to be confident that they are protected by appropriate regulation when they are undertaking any procedure, including an elective one. Dr Alshafey stated in his written reflections that *'Cosmetic surgery is non essential therefore its safety level should be higher than other types of surgery'*. However, he failed to meet the safety standard and has not demonstrated or explained why he failed to provide an even adequate service and so reassure the Tribunal that he would not fail again if allowed to return to practice.

29. Taking all of the above into account, the Tribunal determined that Dr Alshafey's misconduct in carrying out a major surgical procedure in the circumstances set out above breached the trust that a patient was entitled to have in a doctor to such an extent that it was fundamentally incompatible with continued registration. Accordingly, to suspend Dr Alshafey's registration would not sufficiently mark the seriousness of his misconduct, nor would it uphold the overarching objective.

## Erasure

30. The Tribunal went on to consider the sanction of 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:

> *'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*

*c Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients (see further guidance below at paragraphs 129–132 regarding failure to provide an acceptable level of treatment or care).'*

31. Dr Alshafey carried out the Liposuction Procedure in unsafe premises. In those same unsafe premises he undertook an operation for which he had no adequate training and no supervision, he failed to either counsel Patient A appropriately prior to the abdominoplasty and provide appropriate post-operative care and when Patient A developed a serious infection, he delayed in referring her to hospital for treatment. As a result, Patient A suffered significantly.

32. The Tribunal determined that Dr Alshafey's conduct represented a serious departure from Good Medical Practice and he had also shown a reckless disregard for its principles and fundamental tenets of the profession.

33. The Tribunal determined that only erasure would mark the seriousness of such misconduct. Accordingly, the Tribunal determined that erasure is the only sanction sufficient to protect patients. In any event, the Tribunal was satisfied that only erasure would be sufficient to mark the seriousness of Dr Alshafey's misconduct and promote and maintain public confidence in the profession and standards of conduct for the profession.

34. The Tribunal therefore determined that Dr Alshafey's name be erased from the Medical Register.

## Determination on Immediate Order - 22/09/2022

1. Having determined to erase Dr Alshafey's name from the Medical Register, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order.

## Submissions

2. On behalf of the GMC, Ms Tighe submitted that an immediate order was necessary in this case to protect the public. She submitted that it would not be appropriate to permit Dr Alshafey to return to unrestricted practice before the substantive order comes into place. Ms Tighe submitted that if an immediate order was imposed, the interim order of suspension in place would need to be revoked.

## The Tribunal's Determination

3. The Tribunal has taken account of the relevant paragraphs of the SG, in particular paragraphs 172 and 173 which states:

> *'172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor…*
>
> *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.'*

4. In light of the seriousness with which it viewed Dr Alshafey's misconduct, its findings on impairment, and the sanction it has imposed, the Tribunal was of the view that Dr Alshafey may pose a risk to patient safety if permitted to practise without restriction or would comply with any conditions imposed. Further, following Dr Alshafey's disengagement from the GMC and these proceedings, the Tribunal could not be satisfied that Dr Alshafey would practise safely unrestricted. Therefore, the Tribunal determined that it is in the public interest to suspend his registration with immediate effect.

5. The substantive sanction of erasure to be imposed on Dr Alshafey's registration will take effect 28 days from when notice is deemed to have been served upon him, unless he lodges an appeal in the interim. If Dr Alshafey lodges an appeal, the immediate order for suspension will remain in place until such time as the outcome of any appeal is determined.

6. The interim order currently imposed on Dr Alshafey's registration will be revoked when the immediate order takes effect.

7. That concludes the case.

ANNEX A – 24/09/2021

## Application to amend the Allegation under Rule 17(6)

1. At the outset of proceedings, the Tribunal received two applications to amend the Allegation, one on behalf of the GMC and one on behalf of Dr Alshafey.

Application to Amend on behalf of the GMC

2. The first application was made by Ms Tighe, Counsel, on behalf of the GMC pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules') to make two amendments. The first was to amend paragraph 1.a, to insert the words 'and or assess' after measure, as set out in the final version of the Allegation. The second was to correct an error in paragraph 4.d by amending '2.a.iv.ii' to '2.a.iv.i'.

3. Ms Tighe's application to amend the Allegation was not opposed by Mr Holl-Allen KC, on behalf of Dr Alshafey. The Tribunal accepted that the amendments sought by the GMC ensured that the Allegation reflected the evidence, and that such amendments were not opposed. It was satisfied that the proposed amendments could be made without injustice to Dr Alshafey. The Tribunal therefore granted the GMC's application to amend paragraphs 1.a. and 4.d. of the Allegation.

Application to Amend on behalf of Dr Alshafey

4. On behalf of Dr Alshafey, Mr Holl-Allen made an application under Rule 17(6) of the Rules to amend the Allegation by deleting paragraphs 2.b., 3.b. and 6.b.:

> 2. On 5 January 2019 you performed an abdominoplasty combined with liposuction and fat grafts on Patient A ('the Procedure') and:
>
> > b. by not having the adequate training in performing the abdominoplasty procedure you put Patient A at risk of:
> >
> > > i. serious harm;
> > > ii. life threatening consequences.
>
> 3. On 15 January 2019 you consulted with Patient A and you failed to provide adequate postoperative care, in that you:
>
> > b. put Patient A at risk of the following by failing to undertake the actions as set out at paragraph 3.a.:
> >
> > > i. severe harm;
> > > ii. significant morbidity;

iii. life threatening changes.

6. On 13 June 2019 you performed liposuction on a patient ('the Liposuction Procedure') and you:

b. put the patient at risk of:

i. an allergic reaction by failing to undertake the action set out at paragraph 6.a.iii.;
ii. potentially dangerous drug interactions by failing to undertake the action set out at paragraph 6.a.iii.;
iii. unwanted side effects by failing to undertake the action set out at paragraph 6.a.iii.;
iv. serious harm by failing to undertake the action set out at paragraphs 6.a.iii.-6.a.v.ii.;
v. tachycardia by failing to undertake the action set out at paragraph 6.vi.ii.;
vi. lignocaine toxicity by failing to undertake the action set out at paragraph 6.vi.ii.;
vii. syncope by failing to undertake the action set out at paragraph 6.vi.ii..

## Submissions

5. Mr Holl-Allen submitted that paragraphs 2.b., 3.b., and 6.b of the Allegation were all effectively of the same character, in that each referred to an earlier paragraph of the Allegation and alleged that, as a consequence of a previous failing, Dr Alshafey had put Patient A or the liposuction patient at risk of various consequences. Mr Holl-Allen submitted that those three paragraphs of the Allegation were *'bad for repetition'* and caused injustice to Dr Alshafey because they were drafted as separate allegations.

6. He submitted that consideration of the consequences of Dr Alshafey's failures was not for the facts stage of proceedings. He submitted that the deletion of the three paragraphs would not prevent factual issues being determined. He stated that he was not *'seeking to supress relevant evidence'* being given on those matters. Mr Holl-Allen submitted that the inclusion of these allegations of misconduct was unnecessary because the relevant matters were already set out in the Allegation.

7. Following the Legally Qualified Chair (LKC) asking the parties to consider the case of *El-Baroudy v GMC* [2013] EWHC 2894 Admin (*'El-Baroudy'*), Mr Holl-Allen referred the Tribunal to a number of paragraphs in that case, which are set out below. It was suggested to Mr Holl-Allen that the case of *El-Baroudy* established the principle that the alleged consequences of the doctor's actions should be set out in the Allegation and that the GMC should only lead evidence directed to the matters set out in the allegation.

8. Mr Holl-Allen submitted that his application did not offend against the principles in *El-Baroudy* and that the circumstances of this case were very different. so that it was not necessary for the GMC to pursue paragraphs 2.b., 3.b., and 6.b. in order to advance its case against Dr Alshafey.

9. Mr Holl-Allen stated that in *El-Baroudy* the Panel decided a "binary issue" as to whether there was a causal link between Dr El-Baroudy's actions and the death of a patient. He submitted that in Dr Alshafey's case, the question of risk, the subject of the disputed paragraphs, is not binary. He submitted that the Tribunal will be required to determine what, if any risk, the patient was subject to and particularly the extent to which the patient was at risk of those consequences, as a result of Dr Alshafey's alleged omissions. It was Mr Holl-Allen's contention that such matters would be more properly considered in the context of the substantive allegations of failure being found proved and assessed at the impairment stage, not as separately drafted paragraphs of the Allegation.

10. Mr Holl-Allen submitted that in a clinical context, as in this case, the primary reason why there are rules of practice and standards is for the avoidance of risk to patients. He submitted that it was not necessary to say not only did a doctor fail to comply with the rules and standards but in so doing also exposed a patient to risk. He submitted that the issue of the extent to which any failing fell below the reasonable standard gave rise to risk to the patient was a matter for the impairment stage. For all these reasons, Mr Holl-Allen invited the Tribunal to delete paragraphs 2.b., 3.b., and 6.b. of the Allegation.

11. Ms Tighe provided the Tribunal with a chronology of the procedural history in this case and reminded the Tribunal that the draft Allegation had been served on Dr Alshafey on 9 February 2021. She submitted that to withdraw paragraphs 2.b., 3.b., and 6.b. of the Allegation had a potentially extensive impact. She submitted that the Allegation does not represent a case of bad or *'duplicitous'* charging. Ms Tighe submitted that the disputed paragraphs were separate allegations of misconduct that had been formulated based on the expert evidence received by the GMC. Accordingly, Ms Tighe invited the Tribunal to proceed with the Allegation as drafted and refuse the application.

## The Tribunal's Approach

12. The Tribunal had regard to Rule 17(6) of the Rules:

> *(6) Where, at any time, it appears to the Medical Practitioners Tribunal that—*
>
> *(a) the allegation or the facts upon which it is based and of which the practitioner has been notified under rule 15, should be amended; and*
> *(b) the amendment can be made without injustice,*
>
> *it may, after hearing the parties, amend the allegation in appropriate terms.*

13. The Tribunal bore in mind the principles set out in *El-Baroudy*.

14. The Tribunal was mindful that it was required to determine whether leaving the Allegation unamended caused any unfairness to Dr Alshafey. If any unfairness was identified, the Tribunal accepted that it must be remedied.

## The Tribunal's Determination

15. The Tribunal considered whether the Allegation as currently drafted caused any unfairness to Dr Alshafey. It was Mr Holl-Allen's submission that Dr Alshafey was disadvantaged by paragraphs 2.b., 3.b., and 6b of the Allegation because they represented separate allegations of misconduct which set out that he put two patients at risk.

16. The Tribunal reminded itself of the chronology provided by Ms Tighe and noted that Dr Alshafey had been aware of the Allegation against him since February 2021.

17. The Tribunal considered the case of *El-Baroudy* and had particular regard to paragraphs 11, 12, 14 and 30 of the judgment:

> *'11. I have been referred to three authorities that are relevant in this connection. In the case of Roomi v Gmc [2009] EWHC 2188 (Admin) Collins J stated that:*
>
> > *"It is clear from a combination of 15(2)(a) and 17(3), and indeed it is perhaps self evident, that the practitioner faces an allegation which is contained in the notice and no other allegation, unless that notice is amended in accordance with rule 17(3)."*
>
> *12. In the case of Strouthos v London Underground Limited, on an appeal from an order made by the EAT, Pill L J stated at paragraph 12:*
>
> > *"It is a basic proposition, whether in criminal or disciplinary proceedings, that the charge against the defendant or the employee facing dismissal should be precisely framed, and that evidence should be confined to the particulars given in the charge."*
>
> *…*
>
> *14. As I have said already, in this case there was no allegation that the misconduct either caused death or caused the loss of any realistic chance of survival. Had the GMC wished to pursue those allegations, which would have been highly material, then in my judgment they should have been clearly stated in the charges and, in the absence of being stated, evidence directed to those issues should not have been led and the Panel should not in any way have based a judgment as to whether the fitness to practise was impaired or as to sanction on any question of causation, causation being defined as causing death or indeed causing the loss of any real chance of survival.*

…

*30. The first is that, for reasons I have already stated, it seems to me that the Panel should not have borne in mind evidence as to causation, broadly defined in the way that I have done, so as to include not just whether death had resulted on the balance of probabilities but also the loss of a chance. That should not have been taken into account, to my mind, given the way that the charges were laid. It is obviously a matter of substantial importance in considering the gravity of the case to consider outcomes. If the GMC had wanted to allege such an outcome, it should have been alleged specifically. Not being so, the evidence should not have been led.'*

18. The Tribunal was satisfied that *El-Baroudy (above)*, established that a Tribunal should only receive and consider evidence that directly related to the issues raised in the Allegation. The Tribunal accepted that on that basis, were the disputed paragraphs to be withdrawn, there would be limited, if any, scope at the facts stage to test the risk posed to Patient A and the patient who underwent liposuction on 13 June 2019, with the expert witness attending or with Dr Alshafey.

19. Having regard to *El-Baroudy*, the Tribunal was of the view that whether doctor Alshafey had put either of his patients at risk was a matter of fact to be determined in the light of all the evidence, including the expert evidence. In light of that, it was satisfied that the GMC had properly set out such matters in the Allegation. Further, the Tribunal was satisfied that having received the draft Allegation in February 2021, Dr Alshafey and his representatives have had sufficient time to prepare the case to meet the Allegation as a whole, including to the paragraphs relating to risk.

20. The Tribunal found that, where there was an allegation of putting identified patients at risk, no injustice was done to doctor Alshafey in having these matters decided at stage one where the burden of proof rested upon the GMC.

21. The Tribunal was of the view that if the disputed paragraphs were removed from the Allegation that it would be placed in a situation similar to that in the case of *El-Baroudy* if it were then asked to consider risk of harm to the two patients at the impairment stage without reference to any relevant evidence. This would not permit the Tribunal to fulfil its duties.

22. Taking all of the above into account, the Tribunal determined to refuse the application made on behalf of Dr Alshafey to delete paragraphs 2.b., 3.b., and 6.b. of the Allegation.

ANNEX B – 24/09/2021

Application on Admissibility of Evidence Under Rule 34(1)

1. On day one of the hearing, Ms Tighe informed the Tribunal that Patient A had contacted the GMC on 8 September 2021 to say that she did not intend to give evidence at the hearing. She confirmed this during a telephone conversation on 10 September 2021. The GMC had been unable to contact Patient A since then so that it was expected that she would not appear to give evidence before the Tribunal, as had been anticipated.

2. On behalf of the GMC, Ms Tighe therefore made an application pursuant to Rule 34(1) to adduce hearsay evidence given by Patient A in the form of her witness statement dated 28 June 2019.

## Submissions

Submissions on behalf of the GMC

3. In her application, Ms Tighe accepted that Patient A's witness statement was hearsay evidence. Nevertheless, she submitted that it was relevant and in the interests of fairness to admit it, having regard to the principles as set out in *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) (*'Thorneycroft'*).

4. Ms Tighe addressed the nature and extent to which Patient A's statement is contested. She highlighted that the statement had been taken by a GMC solicitor and was signed by Patient A. She submitted that although Patient A's witness statement may have been central to the nature of Dr Alshafey's preoperative consultations, it was not the sole and decisive evidence in support of the entirety of the allegation. In addressing the challenges to the content of Patient A's statement, Ms Tighe accepted that there were some significant differences between Patient A's account and that of Dr Alshafey.

5. Ms Tighe submitted that the GMC had taken reasonable steps to secure Patient A's attendance. In her submissions, she stated that Patient A had confirmed her willingness to give evidence at the time of making the witness statement in August 2019. Ms Tighe submitted that although there had been an intention to provide further updates to Patient A in April 2021, and despite obtaining records of communication with other GMC witnesses, there were no records which detailed any correspondence with Patient A. However, Ms Tighe submitted that contact had been made with Patient A as, on 1 September 2021, a GMC paralegal emailed her in relation to giving evidence and used the phrase 'as advised earlier'. Further, she stated that when Patient A subsequently telephoned the GMC and asked whether she was obliged to give evidence, she was informed that it was in her own interests, and in the interests of fairness to Dr Alshafey, to make every effort to attend. Ms Tighe submitted that on 8 September 2021, when the legal support team were making efforts to arrange a test call, and also in a telephone conversation on 10 September 2021, Patient A informed the GMC that she did not want to give evidence. Ms Tighe submitted that there had subsequently been several unsuccessful attempts to contact Patient A.

6. Ms Tighe acknowledged that the Tribunal should have regard to whether there is a good and cogent reason for the non-attendance of a witness. She submitted that, although

an important feature, the absence of such an explanation does not automatically serve as reason for the evidence not to be admitted. Ms Tighe referred the Tribunal to the telephone notes that the GMC and Patient A had been involved in and described that when Patient A was asked if she was anxious about being questioned, Patient A replied, 'Yes I have thought about it long and hard and do not want to attend'. Ms Tighe made reference to Patient A's health and personal circumstances as set out in her medical records and submitted that these may have indicated a reason for Patient A's non-attendance.

7. Ms Tighe therefore submitted that Patient A's witness statement was relevant and that it was in the interests of fairness for the Tribunal to admit it into evidence.

Submissions on behalf of Dr Alshafey

8. Mr Holl-Allen submitted that to admit Patient A's witness statement into evidence would be unfair in all the circumstances.

9. Mr Holl-Allen submitted that although the absence of a witness could be reflected as going to weight, rather than requiring the evidence to be excluded, this option should not be the routine answer. He further submitted that there was a need to consider fairness prior to hearing all the evidence.

10. Mr Holl-Allen submitted that there had not been provided a good and cogent reason for the absence of Patient A. Although he acknowledged that the absence of a good and cogent reason would not automatically result in the exclusion of the evidence, he submitted that it was an important factor to take into consideration and weigh in the balance in favour of excluding the evidence. Mr Holl-Allen submitted that entries in Patient A's medical records, in the absence of any up-to-date evidence of Patient A's state of health, did not amount to a good and cogent reason.

11. Mr Holl-Allen addressed whether Patient A's witness statement was the sole and decisive evidence. In doing so, he submitted that the Tribunal ought to consider the means of testing the statement's reliability. Mr Holl-Allen submitted that, in the circumstances of the case, there was no effective method of testing the evidence of Patient A, other than through cross examination.

12. He submitted that there were a number of omissions and inaccuracies, including a lack of reference to the in-person consultation on 12 January 2019, which gave rise to a concern about the extent and reliability of Patient A's recall when the statement was made on 28 June 2019. Further, it was his submission that these inaccuracies demonstrated that the evidence was not "demonstrably reliable" but in some respects demonstrably unreliable. Mr Holl-Allen submitted that until the day of the application to admit hearsay evidence, Dr Alshafey was not aware that he may be unable to cross examine Patient A on matters of fundamental importance.

13. Although Mr Holl-Allen acknowledged that it was within the Tribunal's powers to admit some parts of the evidence and not others, he submitted that in this case it risked injustice.

## The Tribunal's Approach

14. The Tribunal noted that the admission of evidence is a matter for the Tribunal to decide having regard to the questions of fairness and relevance. It had regard to Rule 34(1) of the Rules:

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

15. The Tribunal had regard to the case of *Thorneycroft* in which, at paragraph 56, Thomas J considered, that there were seven matters to be taken into account when determining whether to admit hearsay evidence:

> *'56… The decision to admit the witness statements despite their absence required the Panel to perform careful balancing exercise. In my judgment, it was essential in the context of the present case for the Panel to take the following matters into account:*
>
> *(i) whether the statements were the sole or decisive evidence in support of the charges;*
>
> *(ii) the nature and extent of the challenge to the contents of the statements;*
>
> *(iii) whether there was any suggestion that the witnesses had reasons to fabricate their allegations;*
>
> *(iv) the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant's career;*
>
> *(v) whether there was a good reason for the non-attendance of the witnesses;*
>
> *(vi) whether the Respondent had taken reasonable steps to secure their attendance; and*
>
> *(vi) the fact that the Appellant did not have prior notice that the witness statements were to be read.'*

16. In conducting its balancing exercise, the Tribunal bore in mind paragraphs 43 and 44 of *Thorneycroft*:

*'43. In the context of disciplinary proceedings, the issue was considered by the Court of Appeal in NMC v Ogbonna (2010) EWCA Civ 1216. Nicola Davies J allowed the appeal of a nurse against findings of misconduct in a case where the Panel had relied upon a written statement as the sole and decisive evidence against the registrant. It was found that insufficient steps had been taken to secure the attendance of the witness. The NMC had argued that in such cases statements should be admitted almost as a matter of course, and any prejudice to the registrant could be taken into account in assessing the weight which is to be attached to the statement. Both Nicola Davies J and the Court of Appeal rejected this submission. Rule 31(1) of the FTP rules requires the issue of fairness to be considered when considering whether or not to admit the statement at all.*

*44. In R (Bonhoeffer) v GMC (2012) IRLR 37, the Court of Appeal held that Ogbonna did not lay down a general rule that there always had to be good and cogent reasons for the absence of the witness. All such cases are fact-sensitive and the test is the requirement of fairness. Important factors may be a history of animosity between the parties, a conflict of factual evidence and the degree of impact which the evidence would have on the registrant's career.'*

17. The Tribunal bore in mind the relevant principles as laid out at paragraph 45 of Thorneycroft:

*'For the purposes of this appeal, the relevant principles which emerge from the authorities are these:*

*1.1. The admission of the statement of an absent witness should not be regarded as a routine matter. The FTP rules require the Panel to consider the issue of fairness before admitting the evidence.*

*1.2. The fact that the absence of the witness can be reflected in the weight to be attached to their evidence is a factor to weigh in the balance, but it will not always be a sufficient answer to the objection to admissibility.*

*1.3. The existence or otherwise of a good and cogent reason for the non-attendance of the witness is an important factor. However, the absence of a good reason does not automatically result in the exclusion of the evidence.*

*1.4. Where such evidence is the sole or decisive evidence in relation to the charges, the decision whether or not to admit it requires the Panel to make a careful assessment, weighing up the competing factors. To do so, the Panel must consider the issues in the case, the other evidence which is to be called and the potential consequences of admitting the evidence. The Panel must be satisfied either that the evidence is demonstrably reliable, or alternatively that there will be some means of testing its reliability.'*

## The Tribunal's Decision

18. In its deliberations, the Tribunal focused on the issues of relevance and fairness. The Tribunal had regard to the principles set out in paragraphs 43 to 45 of *Thorneycroft (above)* and the questions set out in paragraph 56. The Tribunal approached the issue on the basis that the questions in paragraph 56 were meant to assist in applying the principles, both of which provided guidance for considering fairness and relevance. It found that some of them almost inevitably applied to the whole of a witness's evidence, some to only parts. It bore in mind that a witness's evidence may be sole or decisive in relation to some particulars of the allegation but not others.

19. The Tribunal first considered whether Patient A's evidence was relevant to the issues in the case. It bore in mind that both counsel accepted that Patient A's evidence was relevant to a number of issues in the case. The Tribunal found that Patient A's evidence was relevant to particulars 1 and 3 of the Allegation and likely to be decisive evidence in relation to some aspects of Particular 1.

20. The Tribunal then considered the issue of fairness and accepted that the issue of fairness went to admissibility, not just weight. It bore in mind that Patient A's absence was only made known to Dr Alshafey at the beginning of his hearing, which had the potential to have put Dr Alshafey at a disadvantage with regards to the preparation of his case.

21. The Tribunal considered whether the GMC had demonstrated a good and cogent reason for the absence of Patient A. The Tribunal found that it could derive very limited assistance from patient A's medical records which were limited to history prior to June 2019, some two years prior to this hearing. It also found that, although the GMC may have taken all reasonable steps since Patient A's refusal to give evidence, there was insufficient evidence that the GMC had contacted patient A before September 2021 in circumstances where there was good reason to believe that witness A might require significant support in order to attend to give evidence.

22. The Tribunal bore in mind that in order to admit Patient A's statement in relation to issues where it was the sole or decisive evidence, it must be satisfied that the evidence was demonstrably reliable or that there was some method of testing it. Having examined the areas drawn to its attention by Mr Holl-Allen, the Tribunal concluded that the evidence in Patient A's statement was not demonstrably reliable and indeed there were a number of instances where the witness's evidence was contested and where it appeared to be unreliable.

23. The Tribunal accepted Mr Holl- Allen's submission that there was no means to challenge patient A's evidence if she did not attend to be cross examined.

24. The Tribunal considered whether it would be appropriate to require the witness to attend. It found that in order to determine this matter, Patient A's history and the reason for her absence would require further investigation. The Tribunal decided that, conducting the investigation necessary in the circumstances of this case, would involve an unconscionable

delay, in circumstances where it may well prove inappropriate to compel the witness's attendance in any event. The Tribunal found that would be neither in the public interest nor in the interests of fairness to Dr Alshafey.

25. The Tribunal therefore refused Ms Tighe's application to admit the hearsay evidence provided in the form of a witness statement from Patient A.

ANNEX C – 24/09/2021

## Application to give evidence-in-chief by way of oral evidence

1. At the close of the GMC's case, prior to the Tribunal rising for the day, Mr Holl-Allen indicated that he intended to call Dr Alshafey to give evidence the following day. Mr Holl-Allen informed the Tribunal that he intended to ask supplementary questions of Dr Alshafey for approximately one hour. The following day, before Dr Alshafey was called to give evidence, Ms Tighe addressed the Tribunal and noted that she objected to the length of time allocated to supplementary questions.

2. Mr Holl-Allen therefore made an application under Rule 34(11)(c) to ask Dr Alshafey supplementary questions lasting approximately one hour during his evidence in chief.

## Submissions

Submissions on behalf of Dr Alshafey

3. In making his application, Mr Holl-Allen submitted that the Tribunal's discretion in relation to an application of this kind was greater than that afforded to the ordinary civil court. In exercising its discretion, Mr Holl-Allen submitted that the guiding principle is fairness, to both Dr Alshafey and the GMC.

4. Mr Holl-Allen submitted that it was not his intention to use the time requested to revise the material already in Dr Alshafey's witness statement. Instead, he submitted that asking supplementary questions was necessary and appropriate to allow Dr Alshafey to set out his case, which did not entirely appear from his witness statement. He therefore submitted that he anticipated the same questions would likely be asked during cross-examination or Tribunal questions, if he did not deal with them in chief.

5. Mr Holl-Allen informed the Tribunal that, although he had attempted to provide a fair time estimate of one hour, it was possible that the duration would in fact be less. He outlined the following three areas to which the supplementary questions would relate:

a. details of the preoperative consultation including what was discussed and done by way of physical examination on 05 November 2018;

b. post-operative care and, specifically, Dr Alshafey's assessment of the condition of Patient A's wound on 12 and 15 January 2019; and
c. details of what transpired in the course of the CQC assessment on 13 June 2019.

6. In addressing fairness to the GMC, Mr Holl-Allen conceded that, despite making his position clear to Ms Tighe on the previous day, it would have been better had he provided Ms Tighe with advance warning of his intention to ask supplementary questions and tried to reach agreement with her. Nevertheless, he submitted that the application was neither unreasonable nor unprecedented. Mr Holl-Allen stated that he had endeavoured to make clear the substance of Dr Alshafey's case, including those matters that would arise through the use of supplementary questions, throughout his cross-examination of GMC witnesses. As a consequence, he submitted that granting his application to ask supplementary questions would not be unfair to the GMC, who were aware of the nature of Dr Alshafey's case.

7. Mr Holl-Allen therefore submitted that it was in the interests of fairness to Dr Alshafey and that it would not be unfair to the GMC to allow supplementary questions to be asked.

Submissions on behalf of the GMC

8. Ms Tighe opposed Mr Holl-Allen's application to ask supplementary questions beyond those reflective of introductory questions.

9. Ms Tighe submitted that Mr Holl-Allen had indicated that he would not be willing to reduce the time for which he intended to ask supplementary questions. She therefore submitted that to allow supplementary questions lasting for a duration of one hour would amount to affording Dr Alshafey the opportunity to give evidence in chief orally.

10. Ms Tighe reminded the Tribunal that any evidence Dr Alshafey wished to give ought to have been provided to the GMC not less than 28 days before the date of the hearing. She referred the Tribunal to Rule 34(9) of the Rules:

> *'(9) In relation to proceedings before the Committee or a Medical Practitioners Tribunal, unless otherwise agreed between the parties or directed by a Case Manager, each party shall not less than 28 days before the date of a hearing-*
>
> *(a) provide to the other party a list of every document which he proposes to introduce as evidence; and*
>
> *(b) provide to the other party a copy of every document listed in paragraph (a) which the other party has not previously received.*
>
> *(c) ... '*

11. Ms Tighe submitted that, although she did not object to Mr Holl-Allen asking questions which would assist in settling Dr Alshafey, supplementary questions lasting an hour would be far in excess of what the rules prescribe and would effectively amount to affording Dr Alshafey the opportunity to give oral evidence in chief.

## The Tribunal's Approach

12. The Tribunal bore in mind that the admission of further evidence is a matter for the Tribunal to assess with regard to the questions of fairness and relevance. In making its decision the Tribunal took account of Rule 34(9), 34(9B) and 34(11) of the Rules:

*'34 …*

*(9B) Where a document that is the subject of a notification under paragraph (9A) is a witness statement and the receiving party intends to apply to the Committee or Tribunal under paragraph (11)(c) for the witness concerned to give evidence-in-chief by way of oral evidence, the notification must include a notice to that effect and give reasons for the intended application.*

*…*

*(11) A Committee or Tribunal must receive into evidence a signed witness statement containing a statement of truth as the evidence-in-chief of the witness concerned, unless—*

*(a) the parties have agreed;*

*(b) a Case Manager has directed; or*

*(c) the Committee or Tribunal decides, upon the application of a party or of its own motion, that the witness concerned, including the practitioner, is to give evidence-in-chief by way of oral evidence'*

## The Tribunal's Decision

13. The Tribunal bore in mind that they must hear all the relevant evidence in the interests of justice. In this respect, it considered that parties should take a 'cards on the table' approach. It found that Dr Alshafey's disclosure had been completed at the case management stage and it took the view that the written and signed statement provided by Dr Alshafey had been accepted as his evidence in chief in the usual way.

14. The Tribunal considered that it is likely to be fair to allow questions where matters arise during the course of the other party's case which were not apparent in the original statements served. The Tribunal determined that in the present case, no new evidence had been identified, which Dr Alshafey had not previously had the chance to respond to.

15. The Tribunal decided that allowing extensive examination in chief risked introducing new evidence at this stage which would be unfair to the GMC.

16. In the absence of agreement between parties, the Tribunal concluded that, it would not accept extensive supplementary questions which would amount to oral evidence in chief. It determined that 'settling in' questions and any matters agreed between parties would be permitted.

17. The Tribunal invited Mr Holl-Allen to consider whether he wished to serve a supplementary statement on the GMC and the Tribunal. Mr Holl-Allen declined to do so.

18. Accordingly, the Tribunal refused Mr Holl-Allen's application, on behalf of Dr Alshafey, to ask supplementary questions which would amount to Dr Alshafey giving oral evidence in chief.

ANNEX D – 18/02/2022

The Tribunal's Decision to Adjourn

Background

1. This determination will be read in private. However, as this case concerns Dr Alshafey's misconduct, a redacted version will be published at the close of the hearing with those matters relating to XXX removed.

2. On 17 February 2022, following a finding that Dr Alshafey's fitness to practise was impaired by reason of his misconduct, the Tribunal reconvened via Microsoft Teams to hear submissions on Sanction. Dr Alshafey was not present.

3. The Tribunal learned from Ms Tighe that Dr Alshafey had been XXX in Egypt on or shortly after 12 January 2022. After two requests the Tribunal had sight of email correspondence from [Ms G] dated 17 January 2022 informing the GMC of Dr Alshafey's XXX. This was accompanied by two XXX.

4. XXX.

5. The Tribunal was informed XXX Dr Alshafey had no access to either the telephone or internet. The Tribunal accepted this information because it is consistent with XXX. It noted that in her emails, [Ms G] stated:

> *'… he and me wants to go ahead with the hearing, he can not attend as he still XXX I am discussing with one of his friends that either one of us will represent him in the 17 and 28 hearing XXX'*

## Submissions on Representation

6. Ms H was present at the hearing on 17 February 2022. She informed the Tribunal that she was Dr Alshafey's friend and that she had agreed with [Ms G] to represent Dr Alshafey in his absence. Ms H informed the Tribunal that she had been in communication with [Ms G], but had not spoken directly to Dr Alshafey, given his current circumstances. In response to Tribunal questions, Ms H confirmed that she was a director of the company which ran the clinic from which Dr Alshafey had practised in the UK and had been present during the CQC inspection of the premises where the misconduct took place. She told the Tribunal that she had not been the subject of any criminal, regulatory, or other adverse findings and that neither she nor the company of which she was a director, were a party to civil proceedings related to Dr Alshafey's misconduct.

7. On behalf of the GMC, Ms Tighe took instructions and did not challenge the information provided by Ms H. Ms Tighe submitted that the GMC had no issues with her suitability to represent Dr Alshafey.

## The Tribunal's Approach

8. In determining Ms H's suitability to represent Dr Alshafey, the Tribunal bore in mind Rule 33 of the Rules which states:

> *'*33.
>
> (1) *At a hearing, the practitioner may be represented by-*
>
> (a) *a solicitor or counsel;*
>
> (b) *a representative from any professional organisation of which he is a member; or*
>
> (c) *at the discretion of the Committee or Tribunal, a member of his family or other suitable person.*
>
> (2) *A person who gives evidence at a hearing shall not be entitled to represent or accompany the practitioner at that hearing.*
>
> (3) *The practitioner (either in person or by a representative under paragraph (1)) and the representative for the GMC shall be entitled to be heard by the Committee or Tribunal.'*

9. The Tribunal also bore in mind the MPTS '*Guidance for decision makers on Fit and Proper Persons to provide representation'*. In particular it noted paragraphs 21 and 22 which

set out a number of factors which may have indicated that someone was not a fit and proper person to represent a doctor at a hearing:

> '21
>
> a. *If a person has been removed, or suspended, from a professional register (or their registration is subject to conditions) due to concerns about their fitness to practise.*
>
> b. *If a person has been refused restoration to a professional register or had their licence revoked or refused for a professional activity, due to concerns about their fitness to practise.*
>
> c. *If a person has been barred from working with vulnerable adults and or children by the Independent Safeguarding Authority or Disclosure Scotland or equivalent overseas body.*
>
> d. *If a person has been the subject of any adverse finding or settlement in civil proceedings, particularly in connection with misconduct, fraud, or clinical or medical negligence.*
>
> e. *If a person has been found guilty of a serious criminal offence; this must include, where relevant, any spent convictions excepted under the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975. Offences which may be considered particularly serious include fraud or dishonesty, blackmail, sexual or violent offences, human trafficking and hate crime.*
>
> f. *If a person is subject to any form of civil restraint order or has been found to be a vexatious litigant.*
>
> 22. *Decision makers may also take into account whether the person has been subject to any other justified complaint relating to regulated activities; or is currently the subject of any proceedings of a regulatory or criminal nature, or has been notified of any potential proceedings or any investigation which may lead to those proceedings.'*

## The Tribunal's Decision on Representation

10. The Tribunal noted Ms H's confirmation that she was not the subject of any criminal, civil, regulatory, or other adverse proceedings, and the GMC's agreement in this regard. It was therefore satisfied that Ms H was '*fit and proper to provide representation'* and a '*suitable person'* under Rule 33 for the purpose of these proceedings.

11. However, the Tribunal was particularly concerned whether Ms H was able to represent Dr Alshafey having regard to the fact that she had no direct instructions from him and no current means of communicating with Dr Alshafey. In those circumstances, the

Tribunal considered whether to exercise its powers under Rule 29 of the Rules, to adjourn the hearing in any event.

## Submissions on Adjournment

Submissions on behalf of the GMC

12. On behalf of the GMC, Ms Tighe submitted that the hearing should proceed in any event. Ms Tighe referred the Tribunal to the cases of *R v Jones* [2002] UKHL 5 and *Adeogba v General Medical Council* [2016] EWCA Civ 162 and submitted that the same considerations ought to be applied as those to proceeding in a doctor's absence.

13. She acknowledged that Dr Alshafey was absent through no fault of his own and that he could not be said to have voluntarily absented himself from the hearing. However, Ms Tighe submitted that Dr Alshafey was represented by Ms H, that it was in the best interests of the doctor for a decision to be made on 17 or 18 February 2022, and that it was both fair and proportionate to proceed as any further delay would not be consistent with the overarching objective.

14. Ms Tighe submitted that the Tribunal could not be satisfied that an adjournment would result in Dr Alshafey's presence at a future hearing. She referred the Tribunal to the XXX notes in relation to Dr Alshafey's XXX and submitted that these demonstrated that the continuation of these proceedings was XXX.

Submissions on behalf of Dr Alshafey

15. On behalf of Dr Alshafey, Ms H submitted that the Tribunal should continue as planned because she had spoken to Dr Alshafey before XXX in Egypt. She told the Tribunal that Dr Alshafey was *'XXX and wants to finish as quickly as possible XXX'*. She acknowledged that she had not been able to speak to him since XXX.

## The Tribunal's Approach

16. The Tribunal had regard to Rule 29(2) of the Rules which states:

> *(2) Where a hearing of which notice has been served on the practitioner in accordance with these Rules has commenced, the Committee or Tribunal considering the matter may, at any stage in their proceedings, whether of their own motion or upon the application of a party to the proceedings, adjourn the hearing until such time and date as they think fit.*

17. The Tribunal had regard to the case of *R v Jones* [2002] UKHL 5 ('Jones') in which the following criteria were outlined in deciding whether to proceed in the absence of a doctor:

- The nature and circumstances of the doctor's absence and, in particular, whether the behaviour was deliberate and voluntary and thus a waiver of the right to appear.

- Whether an adjournment is likely to result in the doctor attending the proceedings at a later date.

- The likely length of any such adjournment.

- Whether the doctor, despite being absent, wishes to be represented at the hearing or has waived that right.

- The extent to which any representative would be able to receive instructions from, and present the case on behalf of, the absent doctor.

- The extent of the disadvantage to the doctor in not being able to give evidence having regard to the nature of the case.

- The effect of delay on the memories of witnesses.

- The general public interest and, in particular, the interest of any victims or witnesses that a hearing should take place within a reasonable time of the events to which it relates.

18. The Tribunal considered the case of *Adeogba v General Medical Council* [2016] EWCA Civ 162 ('Adeogba') in which tribunals were reminded that *'there is a burden on … all professionals subject to a regulatory regime, to engage with the regulator, both in relation to the investigation and ultimate resolution of allegations made against them. That is part of the responsibility to which they sign up when being admitted to the profession.'*

## The Tribunal's Decision

19. The Tribunal considered the circumstances and effect of Dr Alshafey's absence under each of the headings set out in the cases referred to above.

Jones

*The nature and circumstances of Dr Alshafey's absence*

20. The Tribunal noted that both parties accepted that this was not a case in which Dr Alshafey had voluntarily absented himself from this hearing. The Tribunal reminded itself of the XXX. The Tribunal also reminded itself of Dr Alshafey's previous positive engagement with these proceedings. He had attended throughout the first two stages of the proceedings and had given evidence to the Tribunal at stage one. In light of this evidence, the Tribunal

determined that it was overwhelmingly likely that that Dr Alshafey was absent from this stage of the hearing only because he XXX.

*The likely length of adjournment and the likelihood of subsequent attendance*

21. The Tribunal had regard to Dr Alshafey's history of engagement with these proceedings. It noted that even after his previous XXX in August 2021, Dr Alshafey had XXX attend the hearing one month later and gave evidence before the Tribunal. The Tribunal was mindful that in her email correspondence with the GMC in 2022, [MS G] had noted that, '*XXX*'.

22. The Tribunal acknowledged that it was unable to determine a precise time when Dr Alshafey may be able to attend the hearing. It determined that based upon the previous XXX between August and September 2021, it was likely that he would XXX within a reasonable time to attend or at least engage sufficiently to XXX state his intentions in relation to engaging with this hearing. XXX.

23. Having regard to the extent of Dr Alshafey's engagement throughout these proceedings, the tribunal found that it was more likely than not that he would engage in the future, XXX.

*Whether Dr Alshafey wished to be represented at the hearing and the extent to which a representative could receive instructions*

24. The Tribunal was mindful that Dr Alshafey had been represented by counsel throughout these proceedings. It noted that even while he XXX, Ms H had attended to protect his interests. Nevertheless, Ms H had not been instructed by Dr Alshafey nor had she any means of taking instructions from him during the proceedings, because Dr Alshafey has no access to telephone or internet.

25. The Tribunal found that this prevented Ms H from being able to make any representation as to Dr Alshafey's current state of insight or remediation, nor his response to any sanction proposed by the GMC. Further, the Tribunal was concerned that even if Ms H were able to speak directly to Dr Alshafey, it was not satisfied that XXX. In arriving at this decision, the Tribunal bore in mind that Dr Alshafey was not currently XXX access to his telephone.

*The extent of the disadvantage to Dr Alshafey in not being able to give his account*

26. The Tribunal was mindful that it had made a finding of serious misconduct in this case, such that Dr Alshafey's fitness to practise was found to be currently impaired. At this stage of the proceedings, the Tribunal were due to consider the appropriate sanction, if any, to impose as a result of that finding of impairment.

27. If the hearing proceeded, Dr Alshafey would not have the opportunity to hear what sanction the GMC asked for, nor would he have a chance to rebut any such request. The

Tribunal reminded itself that Dr Alshafey had submitted a long written document at that impairment stage, upon which the Tribunal had passed comment. The Tribunal also found that Dr Alshafey had been unable to prepare further documents for the Tribunal by reason of XXX. Therefore, if the hearing proceeded, Dr Alshafey would have no opportunity to address the Tribunals concerns either by submitting further documents or making submissions to the Tribunal.

28. In these circumstances, the Tribunal found that the potential disadvantage to Dr Alshafey in being unable to attend, submit evidence, or even instruct his representative, was very significant indeed.

*The general public interest and witnesses*

29. The Tribunal noted that at this stage of the proceedings, there were no further witnesses to be heard. Accordingly, there would be no impact on the memories of witnesses in delaying this hearing.

30. Although the Tribunal acknowledged that it was in the public interest that this hearing took place within a reasonable time of the events to which it relates, it considered that this could not be achieved by what the tribunal found would be an injustice to a doctor who, through no fault of his own, XXX.

Adeogba

31. The Tribunal had regard to the advice given to tribunals to avoid unnecessary adjournments. However, it was of the view that in this case Dr Alshafey had engaged throughout the proceedings. [Ms G] had continued to communicate his circumstances to the GMC even whilst he XXX with no access to his telephone or the internet. In light of this background, the Tribunal considered that the only reason why Dr Alshafey would not have attended the hearing at this stage was because he was unable to participate.

32. The Tribunal noted that in Adeogba it was stated:

> *'Where there is good reason not to proceed, the case should be adjourned; where there is not, however, it is only right that it should proceed.'*

33. In this case, the Tribunal considered that there was it was perfectly clear that Dr Alshafey's XXX demonstrated a good reason not to proceed and that this hearing should therefore be adjourned.

34. The Tribunal is aware that it is ordering an adjournment which neither party has sought it has reminded itself of the information from Ms H that Dr Alshafey told her before he went XXX that he wanted these proceedings to be over and done with. Nevertheless, the Tribunal found that there is all the difference in the world between a general desire for the proceedings to be completed and a decision by Dr Alshafey to waive his right to attend this

hearing, with potentially career ending consequences. The Tribunal is not satisfied that Dr Alshafey has ever addressed that question or XXX to make a decision of such importance or to instruct a representative.

35. The Tribunal had regard to its duty to ensure that the regulatory process was conducted fairly. In the current circumstances, the Tribunal determined that this could not be achieved if the hearing were to proceed.

36. The Tribunal was therefore satisfied that it was in the interests of justice and fairness to Dr Alshafey that it should adjourn for a date to be fixed.

ANNEX E – 22/09/2022

1. This determination will be handed down in private. However, as this case concerns Dr Alshafey's misconduct, a redacted version will be published at the close of the hearing.

Service of Notice of the Hearing

2. Dr Alshafey is neither present nor represented at this adjourned hearing, to decide what if any sanction to impose upon Dr Alshafey. The hearing to decide upon sanction was first listed on 17 February 2022 and adjourned in light of the evidence before the Tribunal regarding XXX.

3. Ms Tighe, Counsel, on behalf of the GMC, provided the Tribunal with documents regarding service of notice of this hearing on Dr Alshafey. This included the most recent correspondence sent from Dr Alshafey's registered email address, which stated it had been sent by [Ms G] on 16 February 2022. The Tribunal was also given a copy of the Medical Practitioners Tribunal Service (MPTS) outcome letter sent by email on 21 February 2022 to Dr Alshafey and Ms H, (Dr Alshafey's representative at the 17 and 18 February 2022 hearing), confirming that the hearing had adjourned part heard. No response was received to the email with the letter attached so it was then posted to Dr Alshafey's registered address by Royal Mail Special Delivery on 23 February 2022. The letter was subsequently returned to the MPTS by Royal Mail with *'Addressee gone away'* selected as the reason.

4. On 3 March 2022, Dr Alshafey and Ms H were emailed again by the MPTS giving him notice in the required form that this Tribunal would reconvene on 21 September 2021, to decide the question of sanction. No response was received so the Notice of Hearing was posted to Dr Alshafey's registered address on 7 March 2022. This letter was also returned to the MPTS by Royal Mail with *'Addressee gone away'* selected as the reason.

5. The Tribunal was provided with email correspondence sent by the GMC on 9 September 2022, to Dr Alshafey's email address, addressed to both Dr Alshafey and [Ms G],

who had been in contact with the GMC in February 2022 on his behalf. The GMC also contacted Ms H by email separately on 9 September 2022 to request an update from her about Dr Alshafey's attendance at this hearing and whether she would be representing him. No responses were received. The Tribunal also had regard to the telephone note from the GMC confirming that the GMC had attempted to telephone Dr Alshafey on the phone number they had for Dr Alshafey but found that number was no longer recognised.

6. The Tribunal had regard to the case of *General Medical Council v Adeogba; General Medical Council v Visvardis* [2016] EWCA Civ 162 which held that the GMC's duty is to communicate with a doctor at the registered address they provide. It is a doctor's duty to ensure that the contact details they provide to the GMC are up to date.

7. The Tribunal had regard to the service bundle provided by the GMC, which contained a copy of the register held by the GMC showing the postal and email addresses held for Dr Alshafey by the GMC, as well as Ms Tighe's submissions. Having considered all of the evidence before it, the Tribunal was satisfied that the GMC had sought to contact Dr Alshafey using the details he had provided and had fulfilled its obligations regarding service. Further, the GMC had gone beyond that in seeking to contact those who had previously represented Dr Alshafey and in attempting to contact him by phone. The GMC had sought to contact Dr Alshafey using all the means at its disposal. All means, which had, up to February 2022, been used by Dr Alshafey or his non-legal representatives to engage with the GMC.

8. Accordingly, the Tribunal was satisfied that notice of the hearing had been served in accordance with Rules 15 and 40 of the General Medical Council (Fitness to Practise) Rules 2004 (as amended) ('the Rules') and paragraph 8 of Schedule 4 to the Medical Act 1983 (as amended).

## Proceeding in Dr Alshafey's absence

9. The Tribunal went on to consider whether it would be appropriate to proceed with this hearing in Dr Alshafey's absence pursuant to Rule 31 of the Rules, which provides that: *'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.'*

10. Ms Tighe invited the Tribunal to proceed in Dr Alshafey's absence. She submitted that Dr Alshafey and those who had previously sought to represent him were aware of these proceedings. She submitted that the GMC has made every effort to contact Dr Alshafey to allow him to participate in this reconvened hearing but that at present, it was not known where Dr Alshafey was or what his circumstances were. Ms Tighe reminded the Tribunal that Dr Alshafey and his representatives had not engaged with the GMC or the MPTS since February 2022. An adjournment had not been sought by Dr Alshafey or his representatives and Ms Tighe submitted that there was no evidence to suggest that a further adjournment,

of any length, would allow Dr Alshafey to engage in these proceedings. Ms Tighe submitted that Dr Alshafey had voluntarily absented himself from these proceedings.

11. The Tribunal was satisfied, in light of the matters set out above that all reasonable efforts had been made to serve Dr Alshafey with notice of this hearing.

12. The Tribunal considered the principles set out in the case of *R v Jones* [2002] UKHL 5 (*'Jones'*). It reminded itself that the discretion to proceed in the absence of a doctor should be exercised with appropriate care and caution, balancing the interests of the doctor with the wider public interest. It had regard to the following in determining whether to proceed in the absence of Dr Alshafey:

- The nature and circumstances of the doctor's absence and, in particular, whether the behaviour was deliberate and voluntary and thus a waiver of the right to appear.
- Whether an adjournment is likely to result in the doctor attending the proceedings at a later date.
- The likely length of any such adjournment.
- Whether the doctor, despite being absent, wishes to be represented at the hearing or has waived that right.
- The extent to which any representative would be able to receive instructions from, and present the case on behalf of, the absent doctor.
- The extent of the disadvantage to the doctor in not being able to give evidence having regard to the nature of the case.
- The general public interest and, in particular, the interest of any victims or witnesses that a hearing should take place within a reasonable time of the events to which it relates.

13. The Tribunal was mindful of the material change in circumstances since its previous decision to adjourn proceedings. In February 2022, the Tribunal saw evidence that Dr Alshafey was XXX and was engaging as best he could through his representatives. However, on this occasion, there was no up-to-date evidence before it about XXX and there had been a complete disengagement by him and his representatives since February 2022, despite extensive efforts to make contact by the GMC. The Tribunal was unable to determine the nature and circumstances of Dr Alshafey's absence given the lack of evidence before it to explain his non-engagement. Previously, despite XXX prior to the hearing commencing in September 2021, Dr Alshafey had fully engaged, given evidence at the facts stage and had provided a remediation bundle at the impairment stage. The Tribunal had previously determined to adjourn the proceedings because it determined that once XXX, Dr Alshafey

was likely to re-engage with the GMC and these proceedings in light of his previous level of engagement. However, the Tribunal found that there was now little likelihood that Dr Alshafey would re-engage in these proceedings, given his disengagement since February 2022.

14. The Tribunal was satisfied that Dr Alshafey was well aware of the Allegation against him, the Tribunal's findings of fact and its determination on impairment. Further, Dr Alshafey was aware that he could be represented at this hearing given his engagement in previous proceedings and the correspondence sent to him by the GMC and then MPTS. There was no evidence before the Tribunal that Dr Alshafey, [Ms G] or Ms H had sought to contact the GMC with updated contact details, a request for an adjournment or any other information about Dr Alshafey. Given the efforts to serve Dr Alshafey with notice of this reconvened hearing, the Tribunal concluded Dr Alshafey had now so disengaged from his regulator in, at the very least, by not even updating his contact details, that he had waived his right to attend these proceedings and had essentially voluntarily absented himself.

15. The Tribunal accepted that there was likely to be a disadvantage to Dr Alshafey were the hearing to proceed to consider what sanction, if any, to impose in his absence. However, this hearing commenced in September 2021 and the Tribunal was required to balance fairness to Dr Alshafey with fairness to the patients in this case, the public and the GMC. Further, the Tribunal had already received evidence and reflection and remediation documentation from Dr Alshafey. In his absence, given the stage of proceedings, he would not miss the opportunity to cross-examine any witness or test the evidence brought against him. The Tribunal acknowledged that Dr Alshafey would be potentially disadvantaged by not being able to further demonstrate his insight and remediation, however he had the opportunity to provide his account and had since disengaged.

16. In such circumstances, having already adjourned to allow Dr Alshafey time to XXX re-engage in these proceedings, the Tribunal determined that there was no longer reason to believe that an adjournment would secure Dr Alshafey's attendance and found that his interests were now outweighed by the need to conclude this hearing in a fair and expeditious manner. It considered that to adjourn again for an indeterminate length of time would serve no useful purpose and could risk undermining public confidence. The Tribunal determined that it was in the public interest to proceed with this hearing today.

17. Therefore, in accordance with Rule 31, the Tribunal has determined to proceed in Dr Alshafey's absence.