PUBLIC RECORD

Dates: 06/07/2026 - 22/07/2026

Doctor:	Dr Yasser Adly ABDEL RAHMAN
GMC reference number:	7079625
Primary medical qualification:	MB BCh 1993 Ain Shams 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:

Legally Qualified Chair	Mrs Claire Lindley
Lay Tribunal Member:	Mrs Karen Naya
Registrant Tribunal Member:	Dr John Moriarty

Tribunal Clerk:	Ms Hinna Safdar

Attendance and Representation:

Doctor:	Not present, not represented
GMC Representative:	Mr Ryan Donoghue, Counsel

Attendance of Press / Public

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

Protecting the Public

Throughout the decision making process the tribunal has borne in mind the statutory duty as set out in s1(1) of the Medical Act 1983 (the 1983 Act) to protect the public. The tribunal has considered the relevance and impact on each of the three distinct parts of public protection 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 - 14/07/2026

1. This determination was handed down in public.

Background

2. Dr Abdel Rahman qualified in 1993 from Ain Shams University in Cairo, Egypt. At the time of the events, he was working as a locum consultant general and colorectal surgeon at the Royal Oldham Hospital ('the Hospital').

3. The allegations that have led to Dr Abdel Rahman's hearing relate to his misconduct.

4. It is alleged by the General Medical Council (GMC) that in 2020, Dr Abdel Rahman failed to provide good clinical care during and after an emergency operation that he performed on Patient A. On 22 September 2020, Patient A's mother had contacted the GMC expressing her concerns about Patient A's care.

5. The allegation is that Patient A was admitted to the Hospital on 24 August 2020, and on the next day underwent emergency surgery ('the Procedure'), performed by Dr Abdel Rahman. In the following days, Patient A reported increasing pain and there were other clinical signs that should have been cause for concern, but that Dr Abdel Rahman failed to respond adequately. On 15 September 2020, after issues were raised by both Patient A's family and nursing staff, another consultant took over Patient A's care. A second emergency operation was carried out. It is alleged that the second surgery revealed that Dr Abdel Rahman had made surgical errors in the Procedure.

6. It is also alleged that, in 2022, Dr Abdel Rahman commenced employment as a locum doctor and failed to comply with conditions imposed on his registration by an Interim Orders Tribunal (IOT) in 2021.

7. Further, it is alleged that when Dr Abdel Rahman subsequently notified the GMC that he had commenced a new post he was dishonest about his start date.

The outcome of applications made during the facts stage

8. The Tribunal granted the GMC's application, made pursuant to Rules 31 and 40 of the GMC (Fitness to Practise Rules) 2004 as amended (the Rules), to proceed with the case in Dr Abdel Rahman's absence. The Tribunal's full decision on the application is included at Annex A.

9. The Tribunal granted the GMC's application, made pursuant to Rule 35(4) of the Rules, that Patient A be referred to as such and remain anonymised. The Tribunal decided that, as this matter related to health and confidential medical records, then he should be anonymised throughout the hearing.

10. On day two of the hearing, the Tribunal granted the GMC's application, made pursuant to Rule 17(6) of the Rules, to amend the Allegation. The Tribunal's full decision on the application is included in Annex B.

The Allegation and the doctor's response

11. The Allegation made against Dr Abdel Rahman is as follows:

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

1. On 25 August 2020 you carried out emergency surgery ('the Procedure') on Patient A and you:

    a. inappropriately performed a gastrojejunostomy in that you made surgical errors, including:

        i. anastomosing the distal end of the proximal jejunum to the stomach to form a closed loop; To be determined

ii. ~~oversewing the staple line that secured the proximal end of the distal small bowel and~~ leaving the proximal end of the distal small bowel ~~it~~ lying in the peritoneal cavity; Amended under Rule 17(6) To be determined

b. failed to seek help with their management in light of their complex medical history, from a:

i. consultant surgical colleague; To be determined

ii. consultant at the Regional Specialist Upper Gastro-intestinal Surgical Centre, To be determined

before performing the Procedure.

2. Between 25 August 2020 and 15 September 2020, you were responsible for the post-operative care of Patient A and you:

a. failed to adequately respond to complications in that you did not respond to warning signs, including:

i. increasing pain; To be determined

ii. failure to improve; To be determined

iii. high nasogastric aspirates; To be determined

iv. bowels not opening; To be determined

b. failed to act upon the results of the one or more Gastrografin swallow x-rays; To be determined

c. failed to adequately consider the concerns raised by nurses and/or other doctors that indicated there was a problem with the Procedure performed; To be determined

d. failed to seek a second surgical opinion; To be determined

e. failed to formally discuss Patient A's care with a colleague; To be determined

f. inappropriately stated that the Procedure had been successful when the clinical or radiological evidence did not support this. To be determined

3. On 16 July 2021 an Interim Order Tribunal imposed an interim order of conditions on

your registration for a period of 12 months ('the Conditions'). To be determined

4. On or around 8 February 2022 you commenced employment as a locum doctor at Affidea Express Care Clinic ('the Post') and you failed to comply with the Conditions in that you did not notify the GMC:

    a. that you had applied for a post outside the United Kingdom; To be determined

    b. that you had accepted the Post before starting it; To be determined

    c. that all relevant people had been notified of your Conditions, as set out in Schedule 1. To be determined

5. On 21 February 2022 you sent an email to the GMC stating '*I have been applying for non surgical post in Ireland as an ED Doctor. I have started as ED doctor this week. I did not know that need to notify GMC for non surgical post'.* To be determined

6. When you acted in the manner described at paragraph 5, you knew that you had commenced employment with Affidea Express Care Clinic on or around 8 February 2022. To be determined

7. Your actions described at paragraph 5 were dishonest by reasons of paragraph 6. To be determined

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

Evidence

Witness evidence

12. The Tribunal received oral evidence on behalf of the GMC from Mr C, a former consultant general and colorectal surgeon and the GMC's expert witness.

13. The Tribunal also received evidence on behalf of the GMC in the form of witness statements from the following witnesses who were not called to give oral evidence:

- Mr D, a consultant general surgeon at the Hospital, dated 14 December 2021 (and supplemental witness statement, dated 5 March 2025)
- Mr E, a consultant general and colorectal surgeon at the Hospital, dated 1 December 2021 (and supplemental witness statement, dated 2 May 2025)
- Mr F, Clinical Director and consultant general and colorectal surgeon at the Hospital, dated 22 November 2022 (and supplemental witness statement, dated 18 March 2025)
- Sister G, a ward sister at the Hospital at the time of the events, dated 10 June 2024 (and supplemental witness statement, dated 15 April 2025)
- Dr H, a Foundation Year 1 (FY1) doctor at the Hospital at the time of the events, dated 12 June 2024 (and supplemental witness statement, dated 31 March 2025)
- Dr I, a speciality doctor in surgery at the Hospital at the time of the events, dated 14 June 2024 (and supplemental witness statement, dated 10 March 2025)
- Dr J, a locum registrar at the Hospital, dated 21 June 2024
- Ms K, an investigation officer at the GMC, dated 29 April 2024
- Ms L, a Human Resources (HR) business partner at Affidea Express Care Clinic ('the Clinic') dated 21 May 2024.

14. Dr Abdel Rahman was not present at the hearing and put forward no witnesses nor witness statements. The Tribunal had been furnished with a statement that he made for a Trust investigation which is undated, along with his response to the GMC investigation ('the Rule 7 Response') received in 2024.

Documentary evidence

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

- Incident investigation report by Northen Care Alliance NHS Group ('the Trust Report'), dated 12 January 2021
- Expert report of Mr C, dated 28 June 2021 (and supplementals reports, dated 2 February 2022 and 11 September 2025)
- Expert report of Professor B, a consultant in abdominal and gastrointestinal radiology, dated 25 April 2022 (and supplemental report, dated 13 May 2025)
- Patient A's medical records, various dates
- Statements for the Trust investigation, various dates

- Statements for police and Inquest, various dates
- Transcript of meeting with Patient A's family, on 11 September 2020
- Dr Abdel Rahman's interim order tribunal (IOT) conditions determination, dated 16 July 2021
- Emails between MPTS and Dr Abdel Rahman, various dates
- Emails between Dr Abdel Rahman and the Clinic dated 28 March 2022
- Dr Abdel Rahman's timesheets from the Clinic.

The Tribunal's Approach

16. The Legally Qualified Chair (LQC) of the Tribunal gave legal advice which is summarised below.

17. The GMC brings this Allegation and the burden of proving each paragraph is on the GMC; there is no burden on the doctor to prove anything.

18. There is one standard of proof in civil and regulatory cases and that is of the balance of probabilities, i.e., whether it is more likely than not that the events occurred as alleged. The probability of the relevant conduct is a matter which can be taken into account when weighing up and deciding whether the event or conduct occurred; this goes to the quality of evidence.

19. The Tribunal should note that none of the witnesses - save for Mr C - have given oral evidence, and that their witness statements have been admitted as their evidence in chief. Dr Rahman has not required their attendance, and they have not been subject to cross examination.

20. The Tribunal should note therefore that a witness statement with a signed statement of truth is also to be treated as if it were given as oral evidence, and also that it should consider any contemporaneous documentary material it has received, for example medical reports. The outcome of the Trust investigation should not be taken into account, but the Tribunal can consider the material that it produced from medical records that it had in its possession.

21. The Tribunal has received reports from two experts and heard evidence from one. They have produced evidence relating to clinical issues that are outside the Tribunal's general knowledge.

22. The Tribunal should consider whether the experts have sufficient expertise to express the opinions that they have on the topics that they have. This is a matter of weight for the Tribunal to assess. A tribunal does not have to accept expert opinion, but if it decides not to accept it, then it must set out its reasons why that is the case.

23. There is an allegation in this case that the matters set out in paragraphs 5-7 if proved, amount to dishonesty. The Tribunal is directed therefore to apply the test as set out by Lord Hughes in *Ivey v Genting Casinos* [2017] UKSC 67. The Tribunal must ascertain (subjectively) the actual state of Dr Abdel Rahman's knowledge or genuinely held belief as to the facts at the material time. The Tribunal would then have to decide whether his actions were dishonest by the objective standards of ordinary decent people.

24. The Tribunal will have in mind that Dr Abdel Rahman is a man of good character. This means that he had no criminal convictions or cautions, or adverse misconduct related regulatory findings. The Tribunal is reminded that cogent evidence of good character is relevant to its consideration of dishonesty. However, good character of itself does not amount to a defence and its significance should not be over inflated. The primary focus should be on the evidence related to the wrongdoing.

25. Unless otherwise directed, the Tribunal should give the words in the paragraphs their ordinary meaning, as would be described in an English dictionary.

The Tribunal's Analysis of the Evidence

26. Before considering the Allegation in detail, the Tribunal decided on its approach to the evidence in this case. It accepted the LQC's advice, and took into account the submissions made by Mr Donoghue, while noting that his submissions are not evidence.

27. The Tribunal was aware that Dr Abdel Rahman had not recently been engaging with the GMC and Tribunal process. He had not responded to the Notice of Allegation, nor the bundle of evidence served on him. He did not attend the hearing. This was not counted against him, but it did mean that the Tribunal did not have the benefit of a statement from him made for these proceedings, nor any oral evidence he might have been able to give during the hearing.

28. To ensure fairness to Dr Abdel Rahman, the GMC had furnished the Tribunal with a statement that he made during the Trust investigation, along with the Rule 7 response. The statement is not dated and not signed, although it is understood that it was received by the

GMC on 1 December 2020. The Rule 7 response is dated 8 January 2024, but again is not signed, and is written in the third person, so it is unclear if it is from Dr Abdel Rahman himself. The Tribunal considered this evidence carefully and gave it what weight it could.

29. When considering the dishonesty allegations, the Tribunal was mindful of Dr Abdel Rahman's good character.

30. The Tribunal was aware of some of the background to this case. Some of the material had been prepared for the Trust Investigation and also for an inquest which was held after Patient A's death on 10 May 2021. The Tribunal was not made aware of the outcome of either.

31. The Tribunal had received a redacted version of the Trust Report. It noted that it had been served on Dr Abdel Rahman during the case management preparation for this hearing. He did not object to it being put before the Tribunal nor challenge its contents. The Tribunal therefore relied on some of the material in the Trust Report and gave it weight as a factual account. In particular, the Tribunal relied on the timeline the report's authors had produced, which had been gleaned from medical records.

32. The Tribunal was aware that Dr Abdel Rahman, in his Rule 7 response, expressed concern that the Hospital was '*pointing the finger of blame*' at him, but the Tribunal saw no evidence of that. It was mindful, however, that there may have been a tension between the reputation of the Trust and the individual, so it was cautious when considering any commentary in the Trust Report. The Tribunal made sure, therefore, that it did not rely on the '*issues identified*' section of the Trust Report when making its own conclusions.

33. The Tribunal noted that the GMC witness statements and the accompanying evidence bundle had all been served on Dr Abdel Rahman. He did not object to the statements being read to the hearing, nor did he challenge any of the evidence. The Tribunal therefore accepted the witness statements as evidence of truth. They are all signed and dated. The accounts the witnesses gave did not differ over time to any large extent, and they were broadly consistent with each other and credible. Even though Dr Abdel Rahman expressed concerns that some of the witnesses might have a conflict of interest because they are colleagues who had worked together for many years, but the Tribunal saw no evidence of that.

34. The Tribunal received a report from an expert, Mr C. In terms of experience, Mr C stated;

> *'I have 27 years' experience as a consultant general and colorectal surgeon including 20 years when I was on call for emergency general surgery. I have held positions of Clinical Director of Surgery for 14 years and Trust Cancer Lead for more than 10 when I was a Consultant at Wigan Infirmary. I was a Cancer Peer Reviewer with the National Program. I was Colorectal Cancer Lead for the Greater Manchester and Cheshire Cancer network from 2004 to 2012 and Medical Director of the network from 2012 to 2013. I was Executive Medical Director of The Christie NHS Foundation Trust from 2013 to 2016.'*

35. The Tribunal was mindful that Mr C did not have all of the material before him, but when he gave his evidence, he assured it that he had enough material upon which to give his settled opinion. The Tribunal noted that he had received 1,536 pages of evidence from the GMC.

36. Dr Abdel Rahman had made a number of comments about the adequacy of Mr C's work and accused him of '*leading a witch hunt'.* The Tribunal saw no evidence of that.

37. Dr Abdel Rahman also claimed that Mr C had a conflict of interest. He said in his Rule 7 response that the;

> *'GMC has appointed a consultant general surgeon from a Wigan Infirmary, who is from the same area, very close to Royal Oldham which raise a concern of relation, if not definitive, with Mr.* [D].*'*

38. As this matter was raised, Mr C responded when he drafted a supplemental report. He said;

> *'I confirm that I did work at Wigan Infirmary from 1993 to 2013 and then moved to The Christie NHS Foundation Trust as Executive Medical Director. I fully retired from the NHS in 2018 and worked clinically in the Independent Sector following that. I did know Mr* [D] *as a trainee in the early 1990's. I have had no contact with him for many years. I do not know the other two consultant surgeons (Mr* [E] *and Mr* [F]*). I do not believe that there is any conflict of interest.'*

39. To be fair to Dr Abdel Rahman, the Tribunal asked Mr C for further detail about his knowledge of, or relationship with, Mr D. He explained that he thought that Mr D was a Senior House Officer or registrar when he was a senior registrar in the 1990s. He then said that when he was the lead clinician for the Greater Manchester and Cheshire Cancer network from 2004 – 2012 and Mr D was working in Oldham on the *'same patch.'* He said that he had never worked with Mr D clinically and did not know him socially. He did not feel that there was a conflict of interest and the Tribunal agreed.

40. The Tribunal therefore accepted that Mr C is an expert in the relevant field and did not have a conflict of interest. It also considered that he had enough material upon which to give his expert opinion. The Tribunal decided therefore that it could rely on Mr C's opinion.

41. The Tribunal received a report from another expert, Professor B. In terms of experience, Professor B stated;

> *'I am a Consultant in Abdominal and Gastrointestinal Radiology at the Bristol Royal Infirmary. I am the lead radiologist for the Upper gastrointestinal multidisciplinary meeting. This meeting deals with all referrals for Upper GI malignancy in the Northern deanery of the South West. I am the author of the Radiological Upper GI cancer guidelines for the Avon, Somerset and Wiltshire Cancer Network. I was the National coordinator for the Gastrointestinal Guidelines for imaging in the Royal College of Radiologist's recent publication 'Making the best use of the department of radiology, version 6.' I am a Fellow of the Royal College of Physicians and a Fellow of the Royal College of Radiologists. I have held my Consultant post for 18 years….*
>
> *…I am a member of the NCEPOD group on the management of acute pancreatitis. I was appointed visiting Professor at the University of the West of England in December 2015. I was appointed as the Interim Medical Director for the Bristol Royal Infirmary in September 2017 to August 2018. I was elected Medical Director for Professional Standards at the Royal College of Radiologists in September 2018 until September 2021. I served as Registrar of The Royal College of Radiologists from September 2018 until September 2021.'*

42. The Tribunal noted that Professor B had not been given all the x-ray and scan results, but it considered that he had enough material upon which to give an opinion. The Tribunal therefore accepted that Professor B is an expert in the relevant field, and it decided therefore that it could rely on his expert opinion.

43. The Tribunal then went on to consider each paragraph of the Allegation in turn.

The Tribunal's Findings

Paragraph 1(a)(i)

44. The Tribunal considered whether, on 25 August 2020, Dr Abdel Rahman carried out emergency surgery ('the Procedure') on Patient A and inappropriately performed a gastrojejunostomy, in which he made surgical errors, including anastomosing the distal end of the proximal jejunum to the stomach to form a closed loop.

45. It was not in dispute that Dr Abdel Rahman was a locum consultant general and colorectal surgeon and was working at the Hospital when Patient A was admitted through the Accident and Emergency Department on 24 August 2020.

46. Patient A presented with a history of six days of abdominal pain. Looking at the Trust Report, the Tribunal saw that Patient A had a complex medical history. It was described as including XXX and a Transient Ischaemic Attack (TIA) 6 years ago. (Mr C explained in his report that XXX).

47. The Tribunal noted that Patient A had a Computed Tomography (CT) scan of the abdomen after his admission, on 25 August 2020, which highlighted;

> *'large pathological lymph nodes, inflammatory mass/abscess incorporating proximal small bowel and moderate ascites. Findings were in keeping with a walled-off perforated necrotic loop of small bowel.'*

48. The Tribunal firstly considered Dr Abdel Rahman's account from his Trust statement of what took place after the CT scan. He confirmed that he reviewed Patient A, considered the CT scan, and decided to operate by making an incision in the abdomen, ('a laparotomy.')

49. Having conducted the laparotomy, Dr Abdel Rahman identified the unhealthy perforated small bowel boundaries and dissected them from their surroundings. He said that the proximal and distal ends of the small bowel were divided by staplers.

(The Tribunal heard from Mr C that 'proximal' in medical terms means nearest to the mouth, and 'distal' the nearest to the anus.) Dr Abdel Rahman described that he carefully dissected a tumour that was present in the small bowel. The Procedure took approximately five hours.

50. The Tribunal understood this description to mean that Dr Abdel Rahman was saying that he removed a tumour mass, and in order to do so had cut the small bowel, creating two ends. He said that there was no or very little proximal length of the jejunum (an upper part of the small bowel) left, because the cut had been made high up near the duodenum (the first part of the small bowel leading directly from the stomach).

51. Due to the amount of bleeding during the Procedure, Dr Abdel Rahman called upon the assistance of the vascular surgery team, who were therefore asked to attend theatre. By the time the vascular surgeon (Dr J) attended, the bleeding had been controlled, but Dr Abdel Rahman stated that Dr J offered to help with the remainder of the Procedure. He said in his statement;

> *'I was happy to have the help of an experienced surgeon Like Mr.* [J] *who has Vascular, General and extensive Transplantation experience at the consultant level. I have welcomed his help.'*

52. Dr Abdel Rahman then stated that he and Dr J had a discussion. He said;

> *'We have decided to do Gastro-Jejunostomy Between the distal end of the Jejunum and the stomach as a safe and feasible drainage procedures and the most feasible option, taking in consideration all these risks.'*

53. The Tribunal understood from this description that Dr Abdel Rahman intended to conduct a procedure known as a 'gastrojejunostomy,' which involves attaching (or 'anastomosing') the jejunum to the stomach so that digestive/bowel continuity is maintained.

54. Dr Abdel Rahman stated that his decision was to attach the distal end of the jejunum to the stomach. He stated that he concluded, after discussion with Dr J, that it was not feasible to try and join the proximal end of small bowel directly to the distal end or, indeed, to perform a Roux-en-Y loop. This was because there was, in his view, a Fe risk of leakage or breakdown. (A Roux-en-Y loop is the procedure whereby the proximal end is joined to the distal end side-on, in addition to that distal end being joined to the stomach, allowing the bile

to drain to the distal bowel). In any event, he asserted, there was insufficient remaining small bowel proximal to the cut to join to anything.

55. Dr Abdel Rahman stated that the procedure they agreed on was carried out successfully, and Dr J then left. He said that he and the anaesthetist then carried out an '*air test,'* which demonstrated that air was able to pass freely between the stomach, the small bowel, and into the colon. (Mr C described this sort of test to the Tribunal. The Tribunal accepted from him that this test demonstrates whether there are any obstructions that would prevent digestive/bowel continuity.)

56. The Tribunal noted that there were others present during the Procedure. There was the anaesthetist and his team, and Mr M who was the surgical specialist registrar. The Tribunal did not have the benefit of statements from them.

57. The Tribunal then moved on to consider the statements made by Dr J.

58. The Tribunal noted that Dr J was a locum vascular registrar at the Hospital at the time of the Procedure. He confirmed in his statement made for the Trust investigation that he was asked to attend theatre on 25 August 2020 as there was major bleeding during a laparotomy. When he attended, the bleeding was controlled but he stayed in theatre to assist Dr Abdel Rahman.

59. Dr J stated that when he attended, he noted that there was a tumour. He described the two 'ends' that had been cut, stating that they had been stapled. Of note is that Dr J stated that the proximal end was in the fourth part of the duodenum, meaning that it was high up in the small bowel, near the join between the duodenum and the jejunum.

60. Dr J confirmed that he and Dr Abdel Rahman discussed the options as to how to ensure bowel continuity and they decided on their third option which was *'to do simple gastro-jejunostomy, which was the most viable and suitable option for restoring the bowel continuity and to provide drainage for gastroduodenal area.'*

61. Dr J confirmed that the other options were to attach the proximal end to the stomach, but he described that proximal end as a '*duodenal stump'* and felt that there was a risk of leakage and potential invasion of the tumour, and that a Roux-en-Y loop procedure posed similar risks.

62. Dr J said that he and Dr Abdel Rahman performed the gastrojejunostomy and that he left before the end of the Procedure.

63. The Tribunal considered these two accounts. They were consistent with each other. They both set out that a retro-colic (behind the colon) gastrojejunostomy was performed, and that the distal end of the jejunum was anastomosed to the stomach. Dr J also supports Dr Abdel Rahman's contention that there was very limited small bowel available in the duodenal area.

64. The Tribunal then went on to consider Patient A's course post operatively. It noted that between 25 August 2020, and 15 September 2020 he was in increasing pain, had high nasogastric aspirates, and that his bowels were not opening. He was failing to improve. These issues are dealt with in detail at Paragraph 2 of the Allegation set out below.

65. As a result of concerns raised about Patient A, the Tribunal noted that a different consultant, Mr D, took over his care on 15 September 2020. Mr D was a consultant general and colorectal surgeon at the Hospital and had been in that role since 1999.

66. The Tribunal took into account the statements that Mr D made for the GMC dated 14 December 2021, the Trust investigation dated 12 October 2020, and the police dated 15 February 2023. He set out in his statements his operation notes, which were made contemporaneous to the events.

67. Mr D described that one of the nurses on the ward, Sister G, approached him to explain that there were a number of issues with Patient A's care. Mr D therefore considered the CT scan of 15 September 2020 and compared it with the operation notes made by Mr M. He felt '*that they did not correlate.'* Mr D felt that it was possible that a Roux-en-Y loop procedure had taken place but that the operation notes only stated that a gastrojejunostomy had been carried out. The Tribunal did not have a copy of the operation note but did have the results of the CT scan of 15 September 2020 which states that *'the stomach and anastomotic Roux-en-Y loops appear distended…'.*

68. The Tribunal noted that, having recognised the discrepancy, and seen the clinical presentation of Patient A, Mr D decided to conduct a second laparotomy.

69. The Tribunal considered Mr D's account of the second procedure carefully. He said that it was extremely difficult due to the presence of the tumour. He then described what he found;

> *'I found that he had a retro-colic gastro-jejunostomy but unfortunately the proximal loop of the resected small bowel had been anatomised* [sic] *to the stomach rather than the distal, this meant that the bowel contents leaving the stomach had nowhere to go apart from back into the stomach in a circular fashion.'*

70. In essence, the Tribunal took this description to mean that instead of Mr Abdel Rahman's assertion that he had attached the distal end of the jejunum to the stomach to ensure bowel continuity, Mr D stated that he found that Mr Abdel Rahman had attached the proximal end instead creating '*a closed loop situation'.*

71. The Tribunal noted that Mr D said that he was able to salvage some of the bowel, take down the previous gastrojejunostomy and perform a *'double barrelled high-output stoma,'* (which involves attaching the cut ends of the bowel to the skin to create a stoma outside of the body.)

72. In his statements, Mr D stated that he asked two consultant colleagues to attend theatre to witness what he had seen. The two consultants - Mr E and Mr F - were shown what Mr D had seen and Mr D stated that he passed a piece of catheter through a hole that he made in the small bowel next to the gastrojejunostomy to show the circular loop that had been created. (Mr C described this sort of test to the Tribunal. The Tribunal accepted from him that this test was similar to the air test described above and that it demonstrates the continuity and flow of the bowel.)

73. The Tribunal then considered the statements of both Mr E and Mr F.

74. Mr E was a consultant general and colorectal surgeon at the Hospital and had been in that role since 2011. In his statement to the GMC, he confirmed that he attended theatre. He said;

> *'Whilst Mr D was operating, I was contacted by one of the theatre staff as Mr D had requested my attendance along with our colleague Mr F, Consultant General and Colorectal Surgeon to confirm his clinical findings. When I arrived in theatre, we both observed Mr D demonstrating that a loop had been created, which was stomach*

duodenum-jejunum anastomosed back to the stomach. Mr D showed us this after passing a catheter through a planned enterotomy.'

75. Mr E later stated that the original Procedure was '*extraordinary.'*

76. Mr F is the Clinical Director and a consultant general and colorectal surgeon at the Hospital and has worked there since January 2020.

77. In his statement to the GMC, Mr F confirmed that he also attended theatre. He said;

'When we arrived in theatre Mr D showed Mr E and I the short segment of small bowel that had been incorrectly attached to the stomach. To obtain a permanent record of the findings, Mr E took a photograph ·of Patient A's abdomen showing the incorrect attachment of the small bowel to the stomach.

I also recall that Mr D performed a test using a catheter and antiseptic fluid to evidence the circular loop that had been inadvertently created. · Once the photograph had been taken Mr E and I left the theatre and Mr D continued with the operation to alleviate Patient A's obstruction.

78. The Tribunal had sight of the photographs that had been taken. In his evidence to the Tribunal, Mr C stated that they were not of good enough quality for any opinion to be drawn from them. The Tribunal noted that Mr Abdel Rahman, in his Rule 7 response, stated that conclusions could be drawn but the Tribunal accepted the expert's opinion and did not do so.

79. The Tribunal also saw from Dr Abdel Rahman's Rule 7 response that he was of the view that Mr E and Mr F could not have seen what they described because they were not in theatre 'scrubs' at the time and therefore would not be near to the patient. However, Mr C explained to the Tribunal that they would have been in theatre clothes which would mean they would be near the patient, with not being asked 'to scrub' just meaning that they would not touch sterile areas. The Tribunal accepted Mr C's opinion that Mr E and Mr F would have had a '*very good view*'.

80. Also, from Dr Abdel Rahman's Rule 7 response, the Tribunal noted that he said that Mr D must have been wrong because there was not enough of the proximal jejunum left to have attached it to the stomach. He said;

> *'There was no proximal length of Jejunum, long enough to be mistaken with the distal end of the Small Bowel as Mr.* [D] *has assumed !!.'*

81. This view, the Tribunal noted, was corroborated by Dr J's description of the proximal end as a *'duodenal stump.'*

82. The Tribunal was however, persuaded by the written statements of Mr D, Mr E and Mr F. They were experienced consultants who gave consistent accounts of what they saw. They had not been challenged during the hearing.

83. The Tribunal also considered the reports of the two experts in this case, Mr C and Professor B.

84. Professor B produced a report dated 25 April 2022, and a supplemental report dated 13 May 2025. He was asked by the GMC to consider the CT scan on 15 September 2022 and give an opinion as to whether they were compatible with '*a situation of a closed loop having been fashioned by the surgeon.'*

85. Before the scan, Patient A had ingested Gastrograffin. The Tribunal understood this to be a liquid that shows up on scans to allow a radiologist to report on whether there are any obstructions to bowel continuity. Where Gastrograffin is present, it is known as 'contrast.'

86. Professor B considered four sequential images from the CT scan of 15 September 2022. By the passage of the contrast, Professor B stated that '*this represents a closed loop obstruction.'* His final conclusion was that;

> *'There is a high closed loop obstruction of the gastrointeatinl* [sic] *tract with a loop of the proximal jejuneum anastomosised* [sic] *to the anterior surface of the stomach.'*

87. Professor B also noted that the radiologist report from the CT scan suggested that a Roux-en-Y loop had taken place, and he took the view that;

> *'The closed loop obstruction from the anastomosis of the jejunum to the anterior stomach has not been appreciated or reported by the reporting Radiologist.'*

88. The Tribunal accepted this opinion and noted that it was entirely consistent with the evidence of Mr D, Mr E and Mr F. It decided that it was also likely that the radiology report of

15 September 2020 reported Roux-en-Y loops because the radiographer would not have appreciated the Procedure that had taken place.

89. The Tribunal was then assisted by the expert reports of Mr C, and the oral evidence he gave at the hearing. Having considered the medical notes, the scans, and the witness statements, Mr C concluded that;

> *'Dr YAR* [Dr Abdel Rahman] *did incorrectly perform a gastrojejunostomy that resulted in the formation of a closed loop.'*

90. Mr C described the seriousness of this error in his first report and said that it was *'totally inappropriate.'* He said;

> *'The actual procedure performed where the distal end of the proximal jejunum was anastomosed to the stomach to form a closed loop represents a significant surgical error which if led* [sic] *would have led directly to the patient's death.'*

91. In his oral evidence to the Tribunal, Mr C described the Procedure that Dr Abdel Rahman carried out as being '*at the extreme end of surgical error,'* and stated that *'it is as bad as it gets for a consultant surgeon'.* He said that the Procedure conducted was *'not known to man.'*

92. The Tribunal accepted from Mr C that the Procedure was '*extremely difficult'* because of Patient A's history and the presence of the tumour. However, it took the view that there was substantial evidence to indicate that an incorrect procedure had been carried out. It relied on the witness statements of Mr D, Mr E and Mr F who are experienced consultants and colorectal surgeons. (This contrasted with Dr J who was a locum vascular registrar.) Patient A was failing to improve, and there were other clinical signs indicating that the Procedure was not a success. The Gastrograffin scans and x-rays suggested that there was an obstruction. Professor B was able to interpret the radiology report of 15 September 2020, confirming that a closed loop had been caused. Mr C confirmed from his reading of all the material that he was of the same view.

93. Having considered the above evidence, the Tribunal concluded that on the balance of probabilities, Dr Abdel Rahman had made a surgical error. The Tribunal was satisfied that he had anastomosed the distal end of the proximal jejunum to the stomach to form a closed loop.

94. Accordingly, the Tribunal found paragraph 1(a)(i) of the Allegation proved.

Paragraph 1(a)(ii)

95. This paragraph stems from the same procedure carried out by Dr Abdel Rahman on 25 August 2020 during which, the Tribunal found, he anastomosed the distal end of the proximal jejunum to the stomach to form a closed loop.

96. The Tribunal also considered whether Dr Abdel Rahman made another surgical error, by leaving the proximal end of the distal small bowel lying in the peritoneal cavity.

97. This aspect of the Allegation relates to what happened to the other 'end' of the jejunum that Mr Abdel Rahman had created when cutting the jejunum.

98. The Tribunal again started its deliberations by considering the statements made by Dr Abdel Rahman and Dr J.

99. Dr Abdel Rahman said there was no proximal jejunum left, and this is corroborated by Dr J who said that there was a staple line nearly at the fourth part of the duodenum i.e. - that there was no or very little proximal length of the jejunum. However, neither Mr Abdel Rahman nor Dr J go onto describe what Dr Abdel Rahman did with the proximal end irrespective of its whereabouts in the bowel, and how much proximal jejunum there was left.

100. In his Rule 7 response, Dr Abdel Rahman quoted from Mr M's statement which the Tribunal had not seen. Mr M had said;

> *'The vascular registrar (*[Dr J]*) came with an idea of anastomosing the distal end of the resected small bowl with the stomach. Mr. Rahman mobilized the distal end through the mesentery of transverse colon and made a retro-colic anastomosis between the stomach and jejunum (gastro jejunostomy). The anastomosis was done in two layers. The other end was left as it is as it was stapled. The vascular registrar assisted Mr Rahman until this point of time. Drains were put in, abdomen was closed.'*

101. The Tribunal took from this that, although Dr Abdel Rahman would say that the end that was stapled was part of the distal jejunum, it did show that an end was left *'as it was as it was stapled.'*

102. The Tribunal then considered the statements of Mr D, Mr E and Mr F. They do not describe what happened to the end of the proximal jejunum but describe only the closed loop between the stomach and the distal jejunum. The Tribunal, however, took into account Mr D's description of the corrective procedure that he carried out – which involved a double-barrelled stoma, using both ends.

103. The Tribunal considered the expert reports of Mr C, and the evidence he gave at the hearing. From his reading of all the material he concluded that;

> *'The proximal end of the more distal small bowel had a staple line securing it which Dr YAR* [Dr Abdel Rahman] *then oversewed and he left this lying freely in the peritoneal cavity. This is a totally inappropriate and unconventional procedure.'*

104. In his oral evidence, Mr C explained that to have created the closed loop between the proximal jejunum and the stomach there must have been a loose end of the distal jejunum. He said that he had heard before of surgeons mixing up the ends before but not leaving one end *'not dealt with'* which is '*extremely wrong.'*

105. The Tribunal concluded on the balance of probabilities that having formed a closed loop, Dr Abdel Rahman must have created a loose 'end'. To come to this conclusion, it relied on the logic that two ends must have been created when the bowel was cut. One end was joined to the stomach to form a closed loop, leaving a second end. It also took into account Mr M's statement that a loose end had been left in the cavity, Mr D's corrective surgery, and Mr C's expert opinion.

106. The Tribunal noted that Mr C's expert view was that even the procedure that Dr Abdel Rahman stated that he had carried out would still have been incorrect. He said in evidence that a failure to deal with the residual part of the small intestine is unacceptable, because it is leaving '*one end not dealt with.'*

107. Considering the evidence, the Tribunal was satisfied that the end of the distal jejunum had been stapled and had been left in the peritoneal cavity, not the end of the proximal jejunum. In other words, Dr Abdel Rahman had got the ends mixed up. The Tribunal accepted Mr C's opinion that even if Dr Abdel Rahman had conducted the Procedure as he described it would still have been wrong not to have dealt with the remaining end.

108. Accordingly, the Tribunal found paragraph 1(a)(ii) of the Allegation proved.

Paragraph 1(b)(i)

109. The Tribunal considered whether, before performing the Procedure, Dr Abdel Rahman failed to seek help with Patient A's management in light of the complex medical history, from a consultant surgical colleague.

110. The Tribunal noted the context of this case. Dr Abdel Rahman was new to the Hospital, a locum and he was not on the specialist register. The Procedure took place out of hours. It was during the COVID-19 pandemic and staffing and specialist availability might have been under pressure.

111. The Tribunal accepted that Patient A's medical history was complex. The CT scan which was performed on 25 August 2020 also demonstrated the seriousness of the case. It showed *'large pathological lymph nodes, inflammatory mass/abscess incorporating proximal small bowel and moderate ascites… in keeping with a walled-off perforated necrotic loop of small bowel.'*

112. The Tribunal was of the view that Patient A's history, coupled with the results of the CT scan, underscored the complexity of the pathology and the need for careful senior-level surgical decision-making.

113. Against that background, the Tribunal balanced whether Dr Abdel Rahman should have, and in not doing so, failed to seek help from a consultant surgical colleague in his management of Patient A before performing the Procedure.

114. The Tribunal firstly noted Dr Abdel Rahman's own account. He did not mention seeking any assistance before the Procedure. He stated that he got assistance from Dr J during the Procedure, and that he '*welcomed his help.'* The Tribunal has already noted however that Dr J was a locum vascular registrar, and in any event the help that he received from him was after the Procedure had commenced.

115. The Tribunal concluded therefore that Dr Abdel Rahman did not seek the help of a consultant surgical colleague before performing the Procedure.

116. The Tribunal was aware in general terms that it is good medical practice for a doctor to act within their competence, seek advice, and consult colleagues where appropriate. No other formal guidance or standards were provided to it.

117. The Tribunal therefore went on to consider Mr C's opinion. In his report he said;

> *'I accept that this will have been an extremely difficult procedure due to Patient A previous surgery and the Fe mass of tumour. If Dr YAR* [Abdel Rahman] *had realised the potential difficulties when he commenced Patient A operation on 15/08/2020 he should have tried to get help from a colleague either at his own Trust or from another Consultant at the Regional Specialist Upper Gastro-intestinal Surgical Centre.'*

118. The Tribunal asked Mr C about this issue when he gave evidence at the Tribunal. When asked about whether there is a duty to seek advice he replied, '*no one can convince me that it is not good medical practice to do that.'* He explained that a surgeon should *'know their limitations'* He said that Dr Abdel Rahman should have shared the care of Patient A, especially as he was a locum and not on the speciality register. He said in his report that surgeons in these circumstances should have a '*low threshold*' for seeking help.

119. The Tribunal concluded that Dr Abdel Rahman did not seek assistance from a consultant surgical colleague. It accepted the opinion of Mr C that he should have done so. It was therefore a failure that he did not.

120. Accordingly, the Tribunal found Paragraph 1(b)(i) of the Allegation proved.

<u>Paragraph 1(b)(ii)</u>

121. The Tribunal then went on to determine whether it was a failure for Dr Abdel Rahman to not have sought help from a consultant at the Regional Specialist Upper Gastro-intestinal Surgical Centre ('the surgical centre.')

122. The Tribunal noted again that there was no evidence that Dr Abdel Rahman had sought any help, save for the assistance given to him by Dr J during the Procedure.

123. The Tribunal took the view that Dr Abdel Rahman should have sought help with Patient A's management and accepted that the surgical centre would have been the best place from which to seek it.

124. The Tribunal again had regard to the opinion of Mr C when he states in his report '*he should have tried to get help from a colleague either at his own Trust or from another Consultant at the Regional Specialist Upper Gastro-intestinal Surgical Centre.'*

125. However, the Tribunal noted from the Trust Report that the Hospital had accepted that there was '*an absence of an organisational framework that guides the practices, supervision or mentoring of locum surgeons.'*

126. The Tribunal therefore asked Mr C about this matter when he gave his oral evidence. He accepted that there was no evidence that Dr Abdel Rahman was made aware of the sources of support available to him.

127. The Tribunal concluded therefore that Dr Abdel Rahman may not have been aware of the surgical centre and how to contact them. While the Tribunal took the view therefore that Dr Abdel Rahman should have consulted *a colleague,* it decided that it could not be *'a failure*' to contact the surgical centre if he did not necessarily know about its existence.

128. Accordingly, the Tribunal therefore found Paragraph 1(b)(ii) of the Allegation not proved.

Paragraph 2(a)

129. The Tribunal considered whether between 25 August 2020 and 15 September 2020, whilst responsible for the post-operative care of Patient A, Dr Abdel Rahman failed to adequately respond to complications in that he did not respond to warning signs. The Tribunal noted that the alleged warning signs included;

(i) Increasing pain
(ii) Failure to improve
(iii) High gastric aspirates
(iv) Bowels not opening

130. The Tribunal accepted that Dr Abdel Rahman was responsible for the post-operative care of Patient A. It then considered whether he had failed to heed the warning signs as listed.

(i) Increasing pain

131. The Tribunal noted that 'pain' is subjective, but that a doctor should be concerned if it is increasing.

132. The Tribunal referred to the Trust Report timeline and the medical notes when considering the pain that Patient A reported after the Procedure.

133. The Tribunal noted firstly that from 27 - 30 August little to no pain was recorded. However, on 31 August, Patient A informed staff of '*breakthrough pain,'* and the on-call pharmacy was contacted for pain relief. Because of continued pain, this pain relief was then changed on 3 September 2020.

134. The Tribunal then noted that between 4-15 September 2020, there are various records of Patient A informing staff he is in pain. The notes variously state that Patient A was in a '*lot of pain,'* had a '*bad day'* and was in '*severe pain.*' On 4 September 2020 notably, the notes state that there was a *'pain crisis.'*

135. The Tribunal noted that during this period of time, a pain specialist became involved, the pain medication was being reviewed and changed, and Patient A was informing staff that the pain was increasing.

136. The Tribunal considered the Trust statement of Mr D who took over the care of Patient A on 15 September 2020. He reported that Patient A '*had been in extreme pain and was requiring PCA analgesia for now nearly three weeks following surgery…'.*

137. The Tribunal also considered the Trust statement of Sister G. She said that she raised concerns about Patient A's pain with Dr Abdel Rahman on 8 September 2020. She raised the matters to a more senior level on 15 September 2020, describing Patient A to be in '*uncontrollable pain.'*

138. The Tribunal concluded from the medical notes, and the statements of both Mr D and Sister G that Patient A was in pain post-surgery and that it increased during the period 25 August 2020 to 15 September 2020.

(ii) Failure to improve

139. The Tribunal considered the Trust timeline to assist it in deciding if Patient A had failed to improve.

140. Because of its finding in relation to (i) above, and (iii) and (iv) below it concluded that, looking holistically, Patient A failed to improve between 25 August 2020 and 15 September 2020. He was in increasing pain, had high nasogastric aspirates and had not opened his bowels.

(iii) High nasogastric aspirates

141. The Tribunal also considered the Trust timeline and the medical notes when considering whether Patient A had high nasogastric aspirates during this period of time. It noted that prior to 13 September 2020 there was a fluctuating picture. For example, there is an entry on 31 August 2020 that states;

> *'…. Large NG (nasogastric) aspirate…'*

142. There is another entry on 4 September 2020 that states;

> *'…Also noted output from NG 1330mls from 03-09-20 and from midnight to 10:30 on 04-09-20 a further 700mls...'*

143. The Tribunal then noted that after 13 September 2020, and until the second procedure on 15 September 2020, the nasogastric aspirates got very high. Mr C reported that the entry on 14 September 2020 states '*Patient feels bloated, 13400*(sic)*ml from NG tube.'* The Tribunal understood 13400ml to be an erroneous entry, but the actual nasogastric aspirate was likely to have been over a litre.

144. The Tribunal again considered the Trust statement of Mr D. He reported that on that 15 September 2020, Patient A '*was requiring PCA analgesia for now nearly 3 weeks following surgery and was continually either vomiting or having large nasogastric aspirates.'*

145. The Tribunal noted that on Dr Abdel Rahman's own account in his Trust statement he stated; '*On 14/09/2020, Patient A has felt bloated and NG tube was reinserted and drained 1300ml.'*

146. The Tribunal concluded from the medical notes, and the statement of Mr D that Patient A had high nasogastric aspirates between the period 25 August 2020 and 15 September 2020.

(iv) Bowels not opening

147. Again, the Tribunal considered the Trust timeline and the medical notes. It noted that there were many entries regarding whether Patient A's bowels had opened and that the absence of any bowel movement was noted almost daily. It was consistently being recorded that Patient A had not opened his bowels nor passed wind.

148. The Tribunal had regard to Sister G's Trust statement. She recounts that Patient A's bowels had not opened when she saw him on 1, 2, 9 and 15 September 2020. During the ward round with Dr Abdel Rahman, Sister G stated that he appeared unconcerned.

149. For example, she said that in the round on 2 September 2020 she said; *'I recall Dr Abdel Rahman being unconcerned with my apprehensions.'*

150. Of the 8 September 2020 ward round Sister G remarked,

> *'…when I attended the ward round… I was quite shocked, and in fact, that was when my anxiety went through the roof because Patient A still had not passed wind or had his bowels open… Mr Rahman's plan was to allow light diet, even though Patient A had not passed wind, which was a clear indication that his bowels were not working.'*

151. The Tribunal took into account the fact that Dr Abdel Rahman in his Trust statement stated that on 11 September 2020 he examined Patient A and performed a digital rectal examination. He said his examination revealed a *'yellowish loose stool in the rectum,'* and that it was witnessed by all the team. However, the Tribunal decided that this is not evidence that Patient A's bowels had opened, and Mr C explained in his evidence to the Tribunal that any faecal matter could have remained in the bowel from before the Procedure.

152. The Tribunal concluded from the medical notes, and the statement of Sister G that Patient A had not opened his bowels between 25 August 2020 and 15 September 2020.

153. Having considered (i), (ii), (iii) and (iv) above, the Tribunal then went onto consider whether Dr Abdel Rahman failed to adequately respond to these warning signs.

154. It noted firstly that Dr Abdel Rahman was involved in the post-operative care of Patient A. He was involved in discussions about pain relief. It was his plan to introduce a light diet and sips of water. He suggested an enema and laxatives. He asked for Gastrografin tests to be done.

155. However, the Tribunal noted the different responses described by both Sister G and Mr D.

156. Sister G described that Patient A's situation was '*very worrying'* and that she was *'concerned'.* She was so concerned that when she saw Patient A's health deteriorating, she felt she had no option but to report that matter to the ward manager. In contrast, she said that Dr Abdel Rahman appeared unconcerned and was dismissive when matters were raised with him.

157. In his Trust statement, Mr D explained that, on 15 September 2020 because Patient A was '*not well'* he took over his care. He then took the decision to perform a second laparotomy.

158. The Tribunal had regard to Mr C's opinion on Dr Abdel Rahman's post-operative care of Patient A. In his report he stated;

> *''Dr YAR's* [Dr Abdel Rahman's] *role was very much to ask the question as to why was having so much pain and what was causing this. There is no evidence in the documentation I have to indicate that Dr YAR* [Dr Abdel Rahman] *gave any consideration to this. He at no time considered that something may have gone wrong surgically.'*
>
> …
>
> *'Dr YAR* [Dr Abdel Rahman] *did not respond to many warning signs that complications were occurring (increasing pain, failure to improve, high NG aspirates, bowels not opening)'.*
>
> …

'Patient A has a stormy post-operative course after his procedure in 25/8/2020. He was in a lot of pain, at times had a very high nasogastric output and was deteriorating rather that [sic] improving. It is my professional opinion that the post-operative course followed by Patient A (after the operation on 25/8/2020) is consistent with the operative findings by Mr [D] *on 16/9/2020.'*

… during the early postoperative period Patient A condition was deteriorating, Dr Rahman continued to manage the case himself and did not seek help. He did not act on the radiological findings following the Gastrograffin xray. He should have sought a second opinion. Eventually a member of the nursing staff asked for help from another consultant. Dr Rahman should have recognised and accepted that Patient A recovery was not going to plan which resulted in a delay in the recognition of the operative error and subsequent management.'

159. When taken as a whole, and bearing in mind Mr C's opinion, the Tribunal was satisfied that there were a number of warning signs about Patient A's post-operative course, and that Dr Abdel Rahman failed to respond adequately to them.

160. Accordingly, the Tribunal found paragraph 2(a) of the Allegation proved.

Paragraph 2(b)

161. The Tribunal went on to consider whether Dr Abdel Rahman failed to act upon the results of the one or more Gastrograffin swallow x-rays during the same time period.

162. The Tribunal reminded itself that Gastrograffin is a liquid that shows up on scans to allow a radiologist to report on whether there are any obstructions to bowel continuity. Where Gastrograffin is present, it is known as 'contrast.'

163. The Tribunal noted from the medical records that four Gastrograffin tests were carried out after the procedure, on 26 August 2020, 27 August 2020, 8 September 2020, and 15 September 2020.

164. The Tribunal considered the radiology reports of these tests. On 26 August 2020, it states that *'there is no contrast in small or large bowel.'* On 27 August 2020, it states *'there may be some diluted contrast in the ascending colon.'* On 8 September 2020 it states

'contrast is noted mainly in the stomach, and there is some contrast in the proximal jejunum. No contrast is seen in the rest of the small or large bowel.' On 15 September 2020, it states '*the colon appears collapsed with traces of oral contrast.'*

165. The Tribunal also noted that a CT scan took place on 9 September 2020, the report of which states that *'Bowel gas pattern is normal.'*

166. In order to assist its findings, the Tribunal considered Professor B's report. He had examined some of the scans himself and had seen the notes of the radiologists. For example, after viewing the image of the scan of 8 September 2020 he stated;

> '*This film was obtained after gastrograffin, an oral contrast media, had been administered. The gastrograffin was administered at 2 O'clock as recorded on the study and the examination was obtained at 00:30. Despite the presence of an NG tube all of the oral contrast remains within the stomach. This was extremely unusual appearance given the length of time from the administration of gastrograffin to the time the examination was obtained.'*
>
> *…*
>
> *'It is usual practice even in the presence of small and large bowel dilatation, for gastrograffin to leave the stomach and pass into the small or large bowel. This has not occurred on this examination and would be consistent with a high level obstruction within the gastrointestinal tract..'*

167. Professor B concluded in his report, from considering the Gastrograffin tests that had taken place that *'There is a high closed loop obstruction of the gastrointeatinl tract with a loop of the proximal jejuneum anastomosised to the anterior surface of the stomach.'*

168. The Tribunal noted that the radiology report of 27 August 2020 states that there may be some diluted contrast in the ascending colon, and Dr Abdel Rahman points this out in his Trust statement. He said;

> *'How did the contrast reach the ascending colon if the was an interruption in the continuity of the GIT as assumed by Mr.* [D]*?!!!!!!!'*

169. In a similar vein, the Tribunal noted that the CT scan of 9 September states that the bowel gas pattern is normal, and Dr Abdel Rahman also points this out in his Trust statement.

170. However, the Tribunal then took into account the opinion of Mr C. He was asked about these results when he gave his evidence. He explained that the radiologist had not spotted that there was a closed loop, and also that there should have been a lot of contrast present in the bowel if the passage was not obstructed. He stated that the contrast is bright white and there should have been obvious loops of it in the small bowel. He said that there was not enough contrast shown. He pointed out that Dr Abdel Rahman had perhaps got '*a false reassurance'* from the report of 27 August 2020, even though it uses the word *'may.'*

171. In his report, Mr C sets out;

> *'The Gastrograffin xray showed that no contrast passed beyond the stomach, it all remained in the stomach as described by Professor [B] in his expert report dated 13/05/2025. I have reviewed the image taken and it is very clear that there is no contrast beyond the stomach. In the case of Patient A therefore, the Gastrograffin did not leave the stomach (due to a closed loop). Had Dr Rahman carried out the surgical procedure on 24/08/2020* [sic] *that is described in the operation record I would normally expect at least some of the contrast (Gastrograffin) to pass through into the small bowel or beyond to the colon. In Patient A case the fact that it did not should have prompted Dr Rahman to consider what the problem was, carry out further investigations and if he was unable to account for the findings and the deterioration of Patient A condition over the subsequent days share the problem with colleagues. This is particularly the case given the concern raised by other healthcare staff. Given the procedure that Dr Rahman performed on Patient A no contrast would be expected to travel into the bowel or be passed as diarrhoea. The fact that Dr Rahman did not act on the result of this radiological investigation does contribute significantly to my opinion that the standard of post operative care fell below that which is acceptable.'*

172. The Tribunal accepted the opinions of both experts. In essence, the Gastrograffin results did not demonstrate that contrast was flowing freely though Patient A's digestive system, and that in turn indicated that there was an obstruction in the bowel.

173. Notwithstanding the possibility that Dr Abdel Rahman was falsely reassured by two of the tests, the Tribunal accepted Mr C's view, which was that Dr Abdel Rahman did not *'take*

stock' regarding the Gastrograffin tests as a whole and the rest of the clinical evidence before him.

174. Accordingly, the Tribunal found Paragraph 2(b) of the Allegation proved.

Paragraph 2(c)

175. The Tribunal considered whether Dr Abdel Rahman failed to adequately consider the concerns raised by nurses and/or doctors that indicated there was a problem with the Procedure performed.

176. The Tribunal noted that this allegation stems from the statements made by Sister G. It accepted that no other members of the ward staff, nor other professional colleagues raised any concerns.

177. The Tribunal first referred to Sister G's GMC witness statement. She described an incident that took place on the ward when she was discussing Patient A's care with Dr I, one of the registrars. They had been considering whether to administer Gastrograffin. She said;

> *'Mr Rahman arrived, and we informed him of the plan to administer Gastrograffin. He immediately responded, "No, you're not doing that." He was using like an angry tone, essentially asserting that he's the consultant, it's his decision and we're not doing that. He was quite rude to [Dr I]. I did try to explain why we had come up with the plan, but because of what he said, we just moved on and it was not documented in my trust statement. That was the part that stands out the most to me. I still feel that if we had done the plan, we would have known sooner that there was a problem.'*

178. Sister G also expressed her concerns about Dr Abdel Rahman's conduct in general terms. She said;

> *'Every meeting with Mr Rahman, including myself, the FY1s, the dietician who were quite involved in Patient A care, he was completely dismissive of everybody's advice, opinions, and concerns. I have never, before or since that day, seen any doctor be that dismissive. Mr Rahman was not interested in what we had to say; he would not act on our concerns and would not take anybody seriously whatsoever, completely disregarding everything everyone said. He gave the attitude that "I'm the consultant, I did the surgery, and you guys don't know anything."'*

179. In her statement to the police, Sister G described Dr Abdel Rahman as '*dismissive,*' and '*unconcerned*' when she raised matters with him. She then said;

> *'…after watching Patient A's health deteriorate over the course of more than two weeks, I felt I had no other option than to report my concerns to the Ward Manager who I understand escalated the concerns to consultant surgeon Mr F and the medical director* [Ms N]. *A meeting was held and I highlighted my concerns to them both. They explained they would speak with Mr RAHMAN and sort it out. Later that day, Patient A was taken for a CT scan of his abdomen. Although I had been due to finish my shift earlier in the day, I remained on duty until I was able to have the CT scan result reviewed. It was at around 17:00hrs when Mr D, also a consultant surgeon, attended T5 with his Registrar,* [XXX]. *It is at this time, and after I explained my concerns regarding Patient A's care and the meeting I had had with Mr F that he agreed to review the CT scan.'*

180. The Tribunal considered the statement made by Dr I and noted that she did not recount the instance when she and Sister G were discussing administering Gastrografin. She said;

> *'I am making this statement following review of the medical records which were available to me In relation to the specific question asked by the police. Unfortunately, due to the passage of time, I am unable to recall the exact events from the two occasions that I met Patient A.'*

181. Dr I described her relationship with Dr Abdel Rahman in general terms. She said;

> *In general, all patients were discussed with the consultants on daily basis, and the decisions would primarily come from them but I can't recall the conversations with the consultant. I also do not have any recollection of anything different from the clinical norm therefore I can't add more information than what is already available in the medical records.'*
>
> *…*

'The GMC asked me whether me and Dr Abdel Rahman got on well. I can confirm that we did, and I would like to add that there were no issues that I saw from a behaviour perspective.'

182. The Tribunal noted that Sister G's evidence had not been challenged by Dr Abdel Rahman and that it was clear that she had escalated her concerns about Patient A's condition and care contemporaneously on 15 September 2020.

183. The Tribunal preferred the evidence of Sister G to that of Dr I. Sister G raised her concerns at the time. Dr I did not remember any incidents due to the passage of time.

184. The Tribunal noted again the importance of shared care in complex cases of this nature and decided that Dr Abdel Rahman did not adequately consider the concerns raised by Sister G.

185. Accordingly, the Tribunal found Paragraph 2(c) of the Allegation proved.

Paragraph 2(d) and Paragraph 2(e)

186. The Tribunal decided to consider these two sub paragraphs together, namely whether Dr Abdel Rahman failed to seek a second surgical opinion and to formally discuss Patient A's care with a colleague.

187. The Tribunal had regard to its findings in relation to Paragraph 1(b) as set out above which it considered similar. The Tribunal again noted the context of this case. Patient A's case was complex. Dr Abdel Rahman was new to the Hospital, working as a locum. He was not on the specialist register.

188. Against that background, the Tribunal balanced whether Dr Abdel Rahman should have, and in not doing so, failed to seek a second surgical opinion or formally discuss the case with a colleague.

189. Again, the Tribunal took into account that Dr Abdel Rahman did not seek any help relating to the care of Patient A, save for the assistance that he got from Dr J during the Procedure. It also noted that he did discuss the 'day to day' management of Patient A when on the ward, and that other surgeons saw Patient A during their ward rounds.

190. Again, the Tribunal was aware in general terms that it is good medical practice for a doctor to act within their competence, seek advice, and consult colleagues where appropriate.

191. The Tribunal noted Mr C's opinion in his expert report that;

> *'It is my professional opinion that, given patient A's post-operative course it would have been the correct path for Dr YAR* [Dr Abdel Rahman] *to seek a second surgical opinion and to formally share Patient A care with a colleague. This course is even more important given that Dr YAR* [Dr Abdel Rahman] *was working as a Locum Consultant and was not on the GMC Specialist Register. In my experience the vast majority of established (including very senior) Consultants would have sought a second opinion when patients follow complicated post-operative courses. It is clear from Dr YAR's* [Dr Abdel Rahman's] *Witness Statement that he was not prepared to accept anything was wrong with his procedure even when the findings of* [Mr D]*, who performed the second operation on 16/09/2020 (witness by two other Consultant surgeons), were shared with him.'*

192. The Tribunal again noted the oral evidence given by Mr C. When asked about seeking advice, he said '*no one can convince me that it is not good medical practice to do that'.* He said that Dr Abdel Rahman should have shared the care of Patient A.

193. The Tribunal concluded that Dr Abdel Rahman did not seek a second surgical opinion, nor formally discuss the Patient A's care with a colleague. It accepted the opinion of Mr C that he should have done so. It was therefore a failure that he did not.

194. Accordingly, The Tribunal found Paragraphs 2(d) and 2(e) of the Allegation proved.

Paragraph 2(f)

195. The Tribunal considered whether Dr Abdel Rahman inappropriately stated that the Procedure had been successful when the clinical or radiological evidence did not support this.

196. The Tribunal had regard to the documentary evidence of Dr Abdel Rahman's communications with Patient A's family, although he had also intimated to others (for example Sister G) that there was no cause for concern.

197. In his statement to the Trust, Mr D stated that there were some '*ongoing issues with the patient and family concerned, regarding Mr Rahman's continual input into the case.'*

198. The Tribunal noted that Dr Abdel Rahman met with Patient A's family on 11 September 2020. It had received a transcript of this meeting, which it considered carefully. It noted firstly that both Patient A's mother and father were present, along with Dr Abdel Rahman, a ward doctor, and a member of hospital staff.

199. Dr Abdel Rahman discussed the Procedure and its outcome with Patient A's mother and father during that meeting. They asked questions of him. Examples of what he said are as follows;

> *'It's all adapted procedures, it will take a while, but actually in his – he's doing very well; he's absolutely doing very well, you know. We were expecting a lot of complications or side effects. There is a very long list of side effects and complications. You can go through the internet and write down "jejunum" – I'll write it down for you because it's a Latin name, you know. So there is a lot of complications that could happen, from the leak, from bleeding, even the drains – we put two drains after the surgery, both of them, nearly nil came out. The whole area was dry and his pick-up was very brilliant, you know, I was very happy about it and the length of time, to be honest.'*
>
> *…*
>
> *So what we did, what I did that time, we connected that part directly to the stomach and it is known surgery. It's not something I invented, you understand? It's documented surgery; it's been done millions of times, you know, it's a very old type of surgery, it's been going on for centuries.'*
>
> *…*
>
> *So at the moment, now, all of these drains has been taken out. He's not moving his bowel as it should. I did an examination for him today and he did have – two times of contrast he swallowed and the X-ray showed that all of this is normal going down, so there's no blockage, it's a normal pathway, it's just a matter of time for adaptation, for that tangled bowel and all of this to understand that there is a new situation we need to manage; we need to change our way now. At this stage, at the moment, I didn't dream of it to be honest, by the level of the surgery. At the time we went out of the surgery, I was not dreaming that I'm not going to be, you know, with any type of complications or side effects after the surgery. Each week, and if I'm not on call I would tell the surgeons on call, "Look at Patient A see, that's our main concern, it's not*

only managing (inaudible).” I discussed that with every single consultant, with the Hospital surgeons and all of them are experts as well. So at our stage now, we are quite happy about where we are.’

…

For the MRI, that’s the issue you raised now, you know, we would discuss that with the oncology here and we don’t mind that, definitely; it is for his benefit. From my point of view, from the surgical point of view, until today I’m on very solid ground, he’s doing perfectly well; it’s only a wound. infection; it’s not an infection haematoma if you need very brief science, you know, it just needs a daily change of dressing. Timing for the bowel to move, it will come eventually because, even the contrast, which is a dye he already ingested., it’s coming down. I did an examination for him today and I can say it’s okay, you know. We are in the right path. So, from the surgical point of view now, I’m really – I will be happy for him to go home. At the stage he will go home I will be very happy and I’m convinced that he can be managed at some stage. There only is the pain control. Once the pain is controlled, I send him straightaway. If we reach, you know, a type of tablets for control of the pain, I will send him home straightaway, because, from the surgical point of view, I’m quite happy about his progress. I think eventually he will be okay in a very short time, a very, very short time. I’m not too much optimistic but I am very, very realistic. He’s doing very well. His bowel will work; eventually it will work. It will take a while but it will work. All the signs are saying that, all the signals are saying that. His wound will heal; it’s a very small one, it’s very small, it’s not something we’re worried about. With a change of dressing, we’ll go ahead. Once we’ve controlled the pain definitely I’ll send him home.’

200. The Tribunal concluded that Dr Abdel Rahman, during this meeting, was explaining that the Procedure was a success and was describing Patient A as improving.

201. From this, the Tribunal concluded that, despite the Procedure having complications, Dr Abdel Rahman told Patient A’s family that the operation had been successful. It also concluded that there was both clinical and radiological evidence that did not support this, as set out above regarding paragraph 2(a) and 2(b).

202. Accordingly, the Tribunal found Paragraph 2(f) of the Allegation proved.

Paragraph 3

203. The Tribunal considered whether on 16 July 2021 an Interim Orders Tribunal (IOT) imposed an interim order of conditions on Dr Abdel Rahman's registration for a period of 12 months.

204. The Tribunal had sight of an IOT determination dated 16 July 2021. It stated;

> *'Mr Abdel Rahman is a Locum consultant in General and Colorectal Surgery, and is currently the subject of a fitness to practise investigation by the General Medical Council ('GMC'). On 5 July 2021, pursuant to section 35C (8) of the Medical Act 1983 as amended ("the Act"), his case was referred to the MPTS by the GMC.'*

205. On 16 July 2021, the IOT Tribunal determined that an order of conditions should be formulated which would provide sufficient safeguards for the protection of members of the public and otherwise in the public interest. As a result, a number of conditions were published.

206. The Tribunal also noticed that the IOT decision was then subject to a review on 21 December 2021, when the same conditions were reimposed.

207. The Tribunal saw an email dated 22 December 2021 which confirms that Dr Abdel Rahman was made aware of the outcome of the review and the conditions that were reimposed.

208. The Tribunal saw the list of conditions. It noted that Dr Abdel Rahman was under a duty to notify the GMC if he applied for a post outside the United Kingdom (condition 2(e)), accepted a post before starting it (condition 2(a)) and that all relevant people had been notified of the conditions as set out in schedule 1 (conditions 2(b) and 8).

209. The Tribunal had sight of Schedule 1 and noted that it listed a number of people that would have to be notified if Dr Abdel Rahman were to gain employment, in particular the Responsible Officer for any employer or locum agency.

210. The Tribunal was satisfied therefore that an IOT imposed conditions on Dr Abdel Rahman's registration on 16 July 2021.

211. Accordingly, the Tribunal found Paragraph 3 of the Allegation proved.

Paragraph 4(a) 4(b),4(c)

212. The Tribunal considered whether on or around 8 February 2026, Dr Abdel Rahman commenced employment as a locum doctor at the Clinic and failed to comply with the conditions in that he did not notify the GMC that;

(a) he had applied for a post outside the United Kingdom,
(b) accepted the post before starting it,
(c) all relevant people had been notified of his conditions as set out in schedule 1

213. The Tribunal considered the conditions that the IOT imposed on Dr Adbel Rahman's registration as set out above and noted that this allegation referred to conditions 2(a), 2(b), 2(e), and 8.

214. The Tribunal noted that a GMC Investigations Officer, Ms K had been assigned to this case, and that she made a statement for these proceedings dated 29 April 2024. She explained her role as;

> *'… as an Investigation Officer, I am responsible for investigating concerns that have been brought to the attention of the GMC regarding the fitness to practice of a doctor. This role includes being a point of contact for doctors, collecting relevant evidence and referring cases to Case Examiners for a decision as to how the case should proceed in accordance with the General Medical Council (Fitness to Practice Rules) 2004 (as amended).'*

215. Ms K confirmed that on 21 February 2022, she received an email from Dr Abdel Rahman informing her that he had been applying for a non-surgical post in Ireland at the Clinic as an emergency department doctor and that he had started as an emergency department doctor that week. Ms K therefore started correspondence with the Clinic asking for the exact dates that Dr Abdel Rahman had started work with them.

216. The Tribunal then noted an email sent to Ms K by Ms O, from the Clinic which stated;

'Dr Yasser Rahman began with a shadow shift with our permanent doctor on the 9th February 2022 and full time on his own on the 12th February 2022.'

217. The Tribunal also had regard to the witness statement of Ms L, a HR Business Partner at the Clinic who confirmed that Dr Rahman joined them as a locum in Cork, Ireland on 8 February 2022 and carried out his first shift on 9 February 2022. She said;

'I can confirm that Dr Abdel Rahman started employment with Affidea on 8 February 2022 because this is when the clock hour report starts. I can confirm Dr Abdel Rahman also carried out his first shift on 9 February 2022 because this is when he got paid 10 hours of basic pay.'

218. The Tribunal also noted that the Clinic had provided time sheets that demonstrated that Dr Abdel Rahman's first shift with them was on 8 February 2022.

219. The Tribunal first considered whether Dr Abdel Rahman had notified any of the relevant persons listed in Schedule 1. Ms L, in her statement said that she could not confirm this because she had not been working at the Clinic at the time that Dr Rahman was there. However, she stated that she had a conversation with a previous HR manager which suggested that he had. She said;

'…During this conversation [Ms P] *said to me in a teams call that there was a doctor at Affidea who had an investigation that was ongoing.* [Ms P] *implied this doctor was on restricted duties which is why he was assigned to 'Express Care' as its more of a GP function clinic as opposed to a hospital, which suited this doctors conditions. Whilst* [Ms P] *didn't mention the name of the doctor, it makes sense that she would have been talking about Dr Abdel Rahman. Although nothing was directly said to me, this was my understanding, that this doctor was unable to carry out surgery but could do GP consultant work. I cannot, however, say whether we know for definite about Dr Abdel Rahman's investigation or conditions.'*

220. The Tribunal accepted that Dr Abdel Rahman may have notified the Clinic of his conditions in line with condition 8. However, in the light of Ms K's statement it was clear that he had not notified the GMC that he had applied for and accepted a post outside the UK. Also, he had not notified the GMC whether he had informed relevant persons of his conditions at the Clinic.

221. Dr Abdel Rahman's email to Ms K, dated 1 March 2022, is a general statement that the '*GMC investigation has been disclosed*'. The Tribunal noted that this is after his acceptance of the role and starting date and lacks any specificity as to the named roles on Schedule 1.

222. In conclusion, the Tribunal was satisfied that the conditions had been imposed, that Dr Abdel Rahman was aware of them, and that he had breached conditions 2(e), 2(a) and 2(b).

223. Accordingly, the Tribunal found Paragraphs 4(a), 4(b) and 4(c) of the Allegation proved.

Paragraph 5

224. The Tribunal considered whether on 21 February 2022, Dr Abdel Rahman sent an email to the GMC stating *'I have been applying for non-surgical post in Ireland as an ED doctor. I have started as ED doctor this week. I did not know that need to notify GMC for non-surgical post.'*

225. The Tribunal reminded itself of the statement of Ms K. She stated that she had received an email on 21 February 2022 from Dr Abdel Rahman informing her that he had been applying for a non-surgical post in Ireland as an emergency department doctor and that he had started as an emergency department doctor that week.

226. The Tribunal had been furnished with a copy of the email. It read;

> *'from: Yasser Abdel Rahman*
> *Sent: 21 February 2022 21:46*
> *To:* [Ms K]
> *Cc:* [XXX]
> *Subject: Non surgical post*
> *Dear Susan, I have been applying for non surgical post in Ireland as an ED Doctor. I have started as ED doctor this week. I did not know that I need to notify GMC for non surgical post.*
> *Regards,*
> *Yasser Yasser Abdel Rahman*
> *M.B.,B.CH , FRCSI'*

227. In the absence of Dr Abdel Rahman this email went unchallenged.

228. Accordingly, the Tribunal found paragraph 5 of the Allegation proved.

Paragraph 6

229. The Tribunal considered whether, when Dr Abdel Rahman acted in the manner described by paragraph 5 above, he knew that he had commenced employment with the Clinic on or around 8 February 2022.

230. The Tribunal took into account the evidence it had considered at paragraph 4 above. The Clinic confirmed that Dr Abdel Rahman started with them on 8/9 February 2022, and there are timesheets that show his first shift as 9 February 2022, when he worked for a ten-hour period.

231. The Tribunal noted that Dr Abdel Rahman wrote the email on 21 February 2022, some 12 days after he had started work at the Clinic.

232. The Tribunal concluded that it could safely infer from the evidence that when Dr Abdel Rahman wrote the email on 21 February 2022, he knew that he had started work at the Clinic on or around 8 February 2022.

233. Accordingly, the Tribunal found Paragraph 6 of the Allegation proved.

Paragraph 7

234. The Tribunal considered whether Dr Abdel Rahman's actions described at paragraph 5, were dishonest by reason of paragraph 6.

235. When considering this aspect of the Allegation, the Tribunal considered the case of *Ivey,* as set out above.

236. The Tribunal noted that the conditions in the IOT determination were clear and that Dr Abdel Rahman was aware of them. He was last sent a copy of the conditions on 22 December 2021 after a review hearing. This was just two months before he sent the email to the GMC.

237. The Tribunal was satisfied that Dr Abdel Rahman's assertion on 21 February 2022 that he had started work with the Clinic '*this week'* was incorrect. He had in fact started 12 days earlier on or around 8 February 2022.

238. The Tribunal noted that 21 February 2022 was a Monday, and that he would therefore have known that he had not started work that day - which is the beginning of the week he was claiming to have started working in.

239. In summary, the Tribunal compared Dr Abdel Rahman's email to the GMC with the other evidence before it. It determined that the information as set out in the email he sent Ms K was inaccurate. It found, as set out above, that he knew he had commenced employment at the Clinic on or around 8 February 2022. The email he sent did not include this information, instead claiming that he began employment in the week of 21 February 2022.

240. The Tribunal did not have the benefit of an explanation of his actions from Dr Abdel Rahman. In the email of 21 February 2022, he stated, '*I did not know that need to notify GMC for non-surgical post.'* However, the Tribunal noted that the conditions are clear and that he had been reminded of them two months earlier. There was no reason why he should think that he did not need to notify the GMC for some roles and not others.

241. The Tribunal considered Dr Abdel Rahman's actions carefully and came to the conclusion that he had not given a credible explanation for them. It then decided that sending emails claiming to have started work '*this week'* when he had started 12 days earlier is dishonest by the (objective) standards of ordinary decent people.

242. Accordingly, the Tribunal found Paragraph 7 of the Allegation proved.

The Tribunal's overall determination on the facts

243. The Tribunal has determined the facts as follows:

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

1. On 25 August 2020 you carried out emergency surgery ('the Procedure') on Patient A and you:

a. inappropriately performed a gastrojejunostomy in that you made surgical errors, including:

i. anastomosing the distal end of the proximal jejunum to the stomach to form a closed loop; **Determined and found proved**

ii. ~~oversewing the staple line that secured the proximal end of the distal small bowel and~~ leaving the proximal end of the distal small bowel ~~it~~ lying in the peritoneal cavity; **Amended under Rule 17(6) Determined and found proved**

b. failed to seek help with their management in light of their complex medical history, from a:

i. consultant surgical colleague; **Determined and found proved**

ii. consultant at the Regional Specialist Upper Gastro-intestinal Surgical Centre, **Determined and found not proved**

before performing the Procedure.

2. Between 25 August 2020 and 15 September 2020, you were responsible for the post-operative care of Patient A and you:

a. failed to adequately respond to complications in that you did not respond to warning signs, including:

i. increasing pain; **Determined and found proved**

ii. failure to improve; **Determined and found proved**

iii. high nasogastric aspirates; **Determined and found proved**

iv. bowels not opening; **Determined and found proved**

b. failed to act upon the results of the one or more Gastrografin swallow x-rays; **Determined and found proved**

c. failed to adequately consider the concerns raised by nurses and/or other doctors that indicated there was a problem with the Procedure performed; **Determined and found proved**

d. failed to seek a second surgical opinion; **Determined and found proved**

e. failed to formally discuss Patient A's care with a colleague; Determined and found proved

f. inappropriately stated that the Procedure had been successful when the clinical or radiological evidence did not support this. Determined and found proved

3. On 16 July 2021 an Interim Order Tribunal imposed an interim order of conditions on your registration for a period of 12 months ('the Conditions'). Determined and found proved

4. On or around 8 February 2022 you commenced employment as a locum doctor at Affidea Express Care Clinic ('the Post') and you failed to comply with the Conditions in that you did not notify the GMC:

a. that you had applied for a post outside the United Kingdom; Determined and found proved

b. that you had accepted the Post before starting it; Determined and found proved

c. that all relevant people had been notified of your Conditions, as set out in Schedule 1. Determined and found proved

5. On 21 February 2022 you sent an email to the GMC stating '*I have been applying for non surgical post in Ireland as an ED Doctor. I have started as ED doctor this week. I did not know that need to notify GMC for non surgical post'.* Determined and found proved

6. When you acted in the manner described at paragraph 5, you knew that you had commenced employment with Affidea Express Care Clinic on or around 8 February 2022. Determined and found proved

7. Your actions described at paragraph 5 were dishonest by reasons of paragraph 6. Determined and found proved

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

Determination on Impairment - 17/07/2026

244. This determination was handed down in public.

245. 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 Abdel Rahman's fitness to practise is impaired by reason of misconduct.

The Evidence

246. The Tribunal reviewed its findings of fact. It did not receive any further evidence at this stage of the proceedings.

Submissions

On behalf of the GMC

247. Mr Donoghue submitted that Dr Abdel Rahman's behaviour amounted to a serious departure from the standards expected of a competent medical practitioner. He drew the Tribunal's attention to Part B step 2 of the 'Medical Practitioners Tribunal Hearings' section of the 'Guidance for use in doctors' hearings' ('the Guidance.') and the five steps it provides for tribunals to follow at this stage.

248. Mr Donoghue invited the Tribunal to consider Dr Abdel Rahman's actions in the facts found proved in four distinct areas of alleged misconduct:

a) Patient A surgical care.
b) Patient A post-operative care.
c) Breach of IOT Conditions.
d) Dishonesty.

249. Mr Donoghue then went through the steps set out in the Guidance in respect of each distinct area.

250. Firstly, Mr Donoghue submitted that there was a legal ground for impairment as required under step 2a. He took the Tribunal through Good Medical Practice (2013) (GMP)

and directed the Tribunal to a number of its relevant paragraphs. He drew the Tribunal's attention to the relevant case law, including in relation to dishonesty.

251. Mr Donoghue submitted that the surgical errors were grave, describing how Dr Abdel Rahman performed an unsafe and unconventional gastrojejunostomy that created a closed loop incompatible with life. He relied on the expert evidence of Mr C, who characterised the Procedure as *'bizarre'* and stated that Patient A would have died without urgent corrective surgery. Mr Donoghue submitted that Dr Abdel Rahman failed to seek help from a consultant colleague despite Patient A's complex presentation, contrary to the expectations of GMP and the standards of a reasonably competent consultant surgeon.

252. Turning to post-operative care, Mr Donoghue submitted that Dr Abdel Rahman repeatedly failed to respond to clear clinical warning signs, including escalating pain, high nasogastric aspirates, failure to improve, and the absence of bowel movement. He submitted that Dr Abdel Rahman disregarded the results of Gastrografin imaging, dismissed the concerns of experienced colleagues, and failed to seek a second opinion. He relied on evidence that Dr Abdel Rahman insisted the Procedure had been successful even when Patient A's condition was deteriorating. He submitted that these omissions represented a reckless disregard for patient safety and a serious breach of collaborative working obligations under GMP.

253. Mr Donoghue submitted that Dr Abdel Rahman's breach of his IOT conditions was deliberate and undermined a system designed to protect patients. By failing to declare his employment at the Clinic he acted in a way that increased risk to the public and demonstrated a lack of insight into regulatory obligations. He submitted that compliance with conditions is integral to maintaining trust in the profession and that Dr Abdel Rahman's conduct fell significantly below expected standards.

254. Mr Donoghue addressed dishonesty. He submitted that Dr Abdel Rahman knowingly misled the GMC about the date he commenced work at the Clinic, doing so with a '*malign'* motive to conceal his breach of conditions. He emphasised that dishonesty is viewed with particular seriousness in medical regulation, citing established authority that even a single act of dishonesty may justify severe sanction. He submitted that Dr Abdel Rahman's dishonesty directly undermined public confidence and represented a serious departure from the integrity required of medical practitioners.

255. Overall, Mr Donoghue submitted that each area of misconduct was serious and that there was, therefore, a legal basis for impairment under step 2a.

256. Mr Donoghue then addressed the Tribunal in relation to step 2(b), which asks the Tribunal to consider the seriousness of the misconduct. He explained that, to some extent, considering the seriousness of the allegations involved looking at the same factors as when considering if the actions amounted to serious professional misconduct at step 2(a). He went through the features of the four distinct areas of misconduct. He drew the Tribunal's attention to the Guidance which sets out non-exhaustive lists of allegations falling at the lower end of seriousness and those at the higher end of seriousness. He took the Tribunal through the table at paragraph 36 of the Guidance, pointing out the features that he felt relevant to the areas of misconduct being considered.

257. So far as Dr Abdel Rahman's clinical failings were concerned, Mr Donoghue asked the Tribunal to conclude Dr Abdel Rahman's overall approach to the surgical procedure on Patient A '*was such that it falls at the top end of the spectrum of seriousness.'* He said also that Dr Abdel Rahman's post-operative care '*not only starts at the higher end of the spectrum of seriousness but includes several factors increasing that seriousness, placing this towards the very top end of that spectrum.'*

258. Mr Donoghue asked the Tribunal to conclude that the breach of IOT conditions fell in the mid-range of the spectrum of seriousness, and that the subsequent act of dishonesty was at the *'at the higher end of the spectrum of seriousness,'* but that it '*would be towards the lower end of that category of such cases.'*

259. Mr Donoghue then moved on to his submissions in relation to step 2c, which asks the Tribunal to consider any relevant context which could have an impact on its assessment of risk to public protection. He stated that although Dr Abdel Rahman had raised some issues about the working environment at the Hospital, they do not provide relevant context to affect the Tribunal's view of his clinical conduct. He said that although Dr Abdel Rahman's role and experience might appear relevant, *'it does not provide any real mitigation for Dr Rahman's actions,'* because of Mr C's comments about how Dr Abdel Rahman should have acted if he were not competent to deal with this complex case. He noted that Dr Abdel Rahman had not disclosed any personal context for the Tribunal to consider.

260. Mr Donoghue therefore submitted that there is no context which should impact upon the Tribunal's assessment of the seriousness of Dr Abdel Rahman's actions in this case.

261. Mr Donoghue then asked the Tribunal to consider how Dr Abdel Rahman has responded to the allegations, as required under step 2d. He said that Dr Abdel Rahman '*was accepting no fault whatsoever for the issues which arose in Patient A's care.'* He drew the Tribunal's attention to both Dr Abdel Rahman's Trust statement, and his Rule 7 response. In them, Mr Donoghue explained, Dr Abdel Rahman accused Mr D of lying about his surgical findings. He criticised the Trust investigation. He attacked Mr C and his approach, as well as Professor B's conclusions. He described the actions of his colleagues at the Hospital as *'malicious.'*

262. Mr Donoghue said, in summary, that Dr Abdel Rahman's responses *'demonstrate a complete refusal on Dr Rahman's part to accept that anything may have gone wrong with his surgery, or even that he did not act as expected in the post-operative care period.'* He said that Dr Abdel Rahman has shown no insight in this case.

263. Mr Donoghue also pointed out that Dr Abdel Rahman had made no response in relation to the breach of the IOT conditions, nor the act of dishonesty, and has since disengaged from the GMC investigation and Tribunal process.

264. Mr Donoghue concluded his submissions in relation to step 2(d) by stating that Dr Abdel Rahman's response *'can only be taken to significantly increase the risk to public protection.'* He reminded the Tribunal of his submissions that Dr Abdel Rahman's clinical findings and the act of dishonesty were already at higher end of the spectrum of seriousness. He said that even in relation to the breach of the IOT conditions, which falls towards the middle of the spectrum of seriousness, the overall risk to public protection is increased due to Dr Abdel Rahman's lack of insight and/or remediation.

265. Mr Donoghue then made submissions about the risk that Dr Abdel Rahman poses to public protection, as set out in step 2(e). He submitted that there is a significant risk to all three limbs of public protection because of the serious misconduct it had found, and the complete lack of insight or evidence of remediation.

266. Mr Donoghue concluded by submitting that Dr Abdel Rahman's fitness to practise is impaired by reason of his misconduct in all four areas of misconduct referred to in this case.

The Relevant Legal Principles

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

268. The Tribunal must assess whether Dr Abdel Rahman poses any current and ongoing risk to public protection. This assessment must be made with reference to the facts found proved at the first stage of the hearing and any further relevant evidence presented to the Tribunal.

269. The Tribunal was advised to take into account Part B of section three of the Guidance. It should also consider whether Dr Abdel Rahman's actions fall within Case Types 2 and 5 in the General Introduction of the Guidance for use in doctors' hearings which are entitled 'dishonesty' and 'clinical concerns,' respectively.

270. Step 2(a) of the Guidance advises the Tribunal to decide whether there is a legal basis for considering impairment. Firstly, therefore, the Tribunal must decide whether the facts as found proved amount to misconduct. 'Misconduct' has no statutory definition. It is a matter for the judgement and experience of the tribunal. However, the misconduct should be 'serious misconduct' before the Tribunal should move to consider fitness to practise. The word 'serious' should be given its ordinary meaning, and the Tribunal should look for an act or omission which falls short of what would be proper in the circumstances.' In the case of *Nandi v GMC* [2004] EWHC, Collins J said that misconduct is conduct which would be regarded as *'deplorable'* by fellow practitioners, and that dishonest conduct can very easily be regarded as serious professional misconduct.

271. The Tribunal should take into account whether Dr Abdel Rahman has departed from the standards set out in GMP 2013 and can take into account the view of the expert as to whether his clinical conduct fell far below the standards expected of him.

272. If, having decided that there is a legal basis to consider impairment then the Tribunal should go onto to consider the other steps in the Guidance set out in 2(b), (c), and (d). This involves considering the seriousness of the conduct, any relevant context, and how the doctor has responded to the Allegation.

273. The Tribunal should take into account Dr Abdel Rahman's hitherto good character when making a determination on impairment. However, the Tribunal is reminded that it has found that Dr Abdel Rahman has acted dishonestly.

274. In the case of *GMC v Nwachuku* 2017 EWHC 2085 Admin it was confirmed that it is unusual for matters involving dishonesty not to result in impairment, especially so where the dishonesty is serious. The Tribunal should also recognise the case of *Nkomo v GMC* 2019 EWHC 2625 Admin which states that dishonesty is generally held to be difficult to remediate. This is because, unlike with clinical errors, where further practice and/or teaching would likely show a practitioner the correct method of practice, the nature of dishonest behaviour goes more to the practitioner's character than learning. Mitigation therefore holds less weight in such cases.

275. The Tribunal should note that Dr Abdel Rahman denied the Allegation. It is advised, however, that it should not necessarily equate the maintenance of innocence with a lack of insight. A tribunal should not punish a doctor for denying misconduct, as they are entitled to do so, but it can weigh up the doctor's account given at the facts stage when assessing insight.

276. Once the steps have been considered as above, the Tribunal should decide what risk, if any, Dr Abdel Rahman poses to public protection and therefore whether he is currently impaired.

277. Whilst there is no statutory definition of impairment, the Tribunal is reminded of the guidance provided by Dame Janet Smith in the *Fifth Shipman Report*, as adopted by the case of '*Grant.'* Dame Smith sets out some features that are likely to be present when impairment is found. These are where a doctor has in the past or is liable in the future to;

a. act so as to put a patient or patients at unwarranted risk of harm,

b. bring the medical profession into disrepute,

c. breach one of the fundamental tenets of the medical profession, and/or

d. act dishonestly.

The Tribunal's Determination on Impairment

278. The Tribunal took into account the submissions made by Mr Donoghue on behalf of the GMC, and accepted the LQC advice, along with the caselaw that had been referred to. It

also considered the Guidance and case types two and five from the General Introduction of the Guidance for use in doctors' hearings.

Step 2a- decide whether there is a legal basis for considering impairment

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

280. The Tribunal noted that this case related to Dr Abdel Rahman's surgical care during the Procedure, the post-operative care, a breach of IOT conditions, and an act of dishonesty.

281. It decided that these represented different aspects of misconduct and therefore should be considered separately.

282. The Tribunal considered the surgical care first, as described in paragraph 1(a)(i), 1(a)(ii), and 1(b)(i) of the Allegation.

283. The Tribunal reminded itself of the decisions it made at stage one of these proceedings. It had found that Dr Abdel Rahman failed to seek assistance from a surgical colleague with the management of Patient A's care before operating on him, then made two significant surgical errors during the Procedure. Dr Abdel Rahman had inappropriately performed a gastrojejunostomy in that he anastomosed the distal end of the proximal jejunum to the stomach to form a closed loop and left the proximal end of the distal small bowel lying in the peritoneal cavity.

284. The expert evidence of Mr C was central to the Tribunal's assessment. It considered Mr C's opinion on the seriousness of Dr Abdel Rahman's surgical errors. In his first report, Mr C concluded;

> *'It is my professional opinion that the overall standard of care that Dr YAR* [Dr Abdel Rahman] *provided to Patient A fell seriously below the standard expected of a reasonably competent consultant in general and colorectal surgery. The reasons are as follows:*

(i) *Performing a totally inappropriate surgical procedure where the distal end of the proximal jejunum was anastomosed to the stomach to form a closed loop.*

(ii) *Failure to recognise (i) above or that this was an appropriate* [sic] *procedure or believing this was an appropriate procedure.*

(iii) *Leaving the proximal end of the distal small bowel (even stapled and oversewn) lying in peritoneal cavity*

(iv) *…*

285. In relation to seeking help, Mr C stated;

'I accept that this will have been an extremely difficult procedure due to Patient A's previous surgery and the Fe mass of tumour. If Dr YAR [Dr Abdel Rahman] *had realised the potential difficulties when he commenced operation on Patient A on 15/08/2020* [sic] *he should have tried to get help from a colleague…'*

'… at the time of operation Dr Rahman was a Locum Consultant Surgeon who was not on the Specialist Register and had only been working at Oldham Hospital for a few days. Patient A was a particularly complex case with multiple comorbidities and a very serious and rare surgical emergency…Many surgeons, including senior and experienced surgeons, would have shared this problem with a colleague. In my professional opinion, Dr Rahman should have tried to involve a consultant surgical colleague when he had identified the level of surgical complexity at the time of laparotomy.'

286. Specifically, about the Procedure, Mr C stated;

'This is a totally inappropriate and unconventional procedure. I can only assume that Dr YAR [Dr Abdel Rahman] *had not realised that he had anastomosed the wrong piece of bowel to the stomach.*
In summary, it is my opinion that, the gastro-jejunostomy procedure performed by Dr YAR [Dr Abdel Rahman] *was not a recognised surgical procedure and represented a significant surgical error.'*
…
'Dr Rahman's procedure can at best be described as bizarre and was a totally unconventional operation that is not compatible with life. Patient A would have died in the post-operative period if it was not for the intervention of Mr D.'
…

'I would expect a surgeon taking on a locum consultant role to have the skills to at least recognise when a complex high risk case falls beyond their level of experience or competence. There is no evidence that Dr Rahman considered this. It is my opinion that he demonstrated that he did not have the experience or expertise to treat a patient of this level of complexity by performing an unconventional surgical procedure (anastomosing the wrong part of the small bowel to the stomach and producing a closed loop) and not recognising that he had done this.'

287. The Tribunal also took into account the evidence that Mr C gave to the Tribunal. He said that what Dr Abdel Rahman had done was '*at the extreme end of surgical error'* and that the Procedure that he had conducted was *'unknown to man.'*

288. Mr C also confirmed in evidence that what Dr Abdel Rahman was intending to do (and maintains that he did do) would also have been '*extremely wrong'* as he would still have left a loose end of part of the bowel lying in the peritoneal cavity.

289. The Tribunal accepted Mr C's opinion. From that, it concluded that the errors that Dr Abdel Rahman made during the Procedure fell seriously below the standard expected of a reasonably competent consultant in general or colorectal surgery. It took particular note of Mr C's opinion that Patient A would have died as a result of the Procedure had it not been for the intervention of Mr D.

290. The Tribunal also took the view that Dr Abdel Rahman had departed from the professional standards set out in GMP. It took the view that the paragraphs engaged were;

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

15 You must provide a good standard of practice and care…

16 In providing clinical care you must:
…
b provide effective treatments based on the best available evidence
…
d consult colleagues where appropriate.'

291. The Tribunal found that Dr Abdel Rahman had failed to recognise and work within the limits of his competence. It was also of the view that he had not provided a good standard of

practice and care or effective treatment. He had not consulted a consultant surgical colleague.

292. The Tribunal concluded that Dr Abdel Rahman's conduct represented a serious departure from the standards expected of him. The errors identified were not marginal or matters of reasonable clinical judgment but constituted fundamental failures in surgical technique and decision-making. The Tribunal therefore concluded that Dr Abdel Rahman's actions amounted to serious professional misconduct.

293. The Tribunal then considered the post-operative care as described in paragraphs 2(a)-(f) of the Allegation.

294. The Tribunal reminded itself of its findings at stage one of these proceedings. It noted that, after the Procedure, Dr Abdel Rahman failed to adequately respond to a number of clinical warning signs about Patient A's recovery over a three-week period. Dr Abdel Rahman also failed to act upon the results of the Gastrografin swallow x-rays. The Tribunal also noted that Dr Abdel Rahman did not seek a second surgical opinion, and did not heed the concerns of others, in particular Sister G. He also stated that the Procedure had been a success, particularly to Patient A's family, when both the clinical and radiological evidence did not support this.

295. The Tribunal again took into account Mr C's opinion. In relation to the post-operative care, he concluded;

> *'It is my professional opinion that the overall standard of care that Dr YAR* [Dr Abdel Rahman] *provided to Patient A fell seriously below the standard expected of a reasonably competent consultant in general and colorectal surgery.*
>
> *The reasons are as follows:*
> …
> *(iv) Failure to recognised deteriorating post-operative recovery and acting on it.*
> *(v) Failure to act on Gastrograffin swallow xray findings.*
> *(vi) Failure to formally seek the help of a colleague when the patient was making a poor recovery, particularly given that Dr YAR* [Dr Abdel Rahman] *was working as a Locum Consultant and was not on the Specialist Register.*
> *(vii) Failure to accept that he could have made or had made a surgical error.'*

296. Mr C also said;

> *'…during the early post-operative period Patient A's condition was deteriorating, Dr Rahman continued to manage the case himself and did not seek help. He did not act on the radiological findings following the Gastrograffin xray. He should have sought a second opinion. Eventually a member of the nursing staff asked for help from another consultant. Dr Rahman should have recognised and accepted that recovery was not going to plan which resulted in a delay in the recognition of the operative error and subsequent management.'*

297. The Tribunal accepted the view of Mr C and concluded that Dr Abdel Rahman's actions after the Procedure, and before the corrective surgery on 15 September 2020, fell far below the standards expected of him. It decided that having made the surgical errors, his actions post-surgery compounded the seriousness of his clinical failings.

298. The Tribunal considered whether Dr Abdel Rahman's post-operative management of Patient A amounted to misconduct under GMP and the relevant professional standards. It took the view that paragraphs 15 and 16 were engaged (as set out above.) It also considered the following paragraphs of GMP to be relevant;

> *22 You must take part in systems of quality assurance and quality improvement to promote patient safety. This includes:*
> *…*
> *b regularly reflecting on your standards of practice and the care you provide*
>
> *35 You must work collaboratively with colleagues, respecting their skills and contributions.*
>
> *36 You must treat colleagues fairly and with respect.*
>
> *37 You must be aware of how your behaviour may influence others within and outside the team.*

299. The Tribunal was also mindful of the impact that Dr Abdel Rahman's actions had on Patient A. He was in increasing pain for a period of three weeks and had to undergo a second operation. Patient A's family were increasingly concerned about his care and yet were given

an incorrect picture of his post-operative condition by Dr Abdel Rahman when he met with them. The Tribunal decided therefore that paragraph 55 of GMP was also engaged. It reads;

> *55 You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:*
> *a put matters right (if that is possible) …*

300. The Tribunal concluded that Dr Abdel Rahman's actions fell far below the standards expected of him, and that he had departed from the professional standards set out in GMP in a number of respects. It decided also that fellow practitioners would be extremely concerned about this standard of performance, and the way Dr Abdel Rahman communicated with Patient A's family.

301. The Tribunal decided, therefore, that Dr Abdel Rahman's post-operative clinical failings amounted to serious professional misconduct.

302. The Tribunal then considered the breach of IOT conditions as described in paragraphs 3 and 4 of the Allegation. Again, the Tribunal reminded itself of the findings it had made.

303. Pending this Tribunal hearing about the clinical issues, a number of conditions had been imposed on Dr Abdel Rahman's registration. They were imposed in order to protect the public. Dr Abdel Rahman breached three of the conditions.

304. The Tribunal decided that, by breaching the IOT conditions, Dr Abdel Rahman had not complied with the requirements of his regulator and that this could have put members of the public at risk.

305. The Tribunal took the view that Dr Abdel Rahman had departed from the professional standards set out in GMP in respect of these actions. In particular, it took the view that the paragraphs engaged were;

> *65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.*
>
> *73 You must cooperate with formal inquiries and complaints procedures and must offer all relevant information while following the guidance in Confidentiality*.

306. The Tribunal concluded therefore that the fact that Dr Abdel Rahman had breached three IOT conditions also amounted to serious professional misconduct.

307. Lastly, the Tribunal considered the act of dishonesty as described by paragraphs 5-7 of the Allegation.

308. The Tribunal reminded itself that when Dr Abdel Rahman wrote to the GMC about the post he had secured at the Clinic, he was dishonest about his start date.

309. The Tribunal had regard to the decision in the case of *Nandi* as set out above, which confirms that dishonesty is inherently serious and is ordinarily characterised as misconduct. The Tribunal accepted that dishonesty, even when arising in a limited context, is capable of undermining public confidence in the profession and the regulatory system. It therefore concluded that Dr Abdel Rahman's conduct represented a significant departure from the standards expected of a responsible medical practitioner.

310. The Tribunal also took the view that Dr Abdel Rahman had departed from the standards set out in GMP. Acting in a dishonest manner is likely to erode the trust that the public holds in the medical profession. It took the view that paragraph 65 was again engaged as was paragraph 66;

> *66 You must always be honest about your experience, qualifications and current role.*
> *…*

311. The Tribunal determined that the dishonest behaviour constituted a deliberate act inconsistent with the core professional duty to act with integrity. Given the seriousness with which dishonesty is regarded in regulatory proceedings, the Tribunal concluded that Dr Abdel Rahman's conduct amounted to serious professional misconduct.

312. The Tribunal decided that Dr Abdel Rahman's clinical misconduct during and after the Procedure, the breach of the IOT conditions, and the act of dishonesty engaged a number of paragraphs of GMP, not least the introductory paragraph which reads;

> *1 Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.*

313. The Tribunal therefore decided that there was a legal basis for it to consider impairment. It found that Dr Abdel Rahman's actions amounted to serious professional misconduct, both in terms of the clinical failings during the Procedure and post- operatively, and the breach of three IOT conditions and associated act of dishonesty.

Step 2b- decide where on the spectrum of seriousness lies

314. The Tribunal then went on to consider where on the spectrum of seriousness the allegation lies. It noted again that this case involved the four different aspects of misconduct and dealt with each in turn.

315. The Tribunal first considered where Dr Abdel Rahman's surgical care fell on the spectrum of seriousness. It had regard to Mr C's opinion, as set out above, which emphasised the gravity of the errors and the extent to which Dr Abdel Rahman's actions departed from the standards expected of a reasonably competent consultant in general and colorectal surgery.

316. The Tribunal then noted paragraphs 28, 29, 30 and 31 of Part B of the Guidance which set out the type of allegations that may fall at the lower, mid-range, and higher end of the spectrum of seriousness. There is a non-exhaustive list of the types of misconduct that might fall at both lower and higher end of the spectrum, with the mid-range being described as misconduct falling between the two.

317. The Tribunal noted that allegations usually falling at the lower end of the spectrum of seriousness and which due to their nature are more likely to be easily remedial in relation to clinical concerns, could be;

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

318. In contrast, the Tribunal noted that allegations that are likely to fall at the high end of the spectrum of seriousness, in relation to clinical concerns could be;

> *'clinical failings that are not considered easily remediable, including those amounting to gross negligence or recklessness about a risk of serious harm to patients.'*

319. The Tribunal considered this aspect of the case carefully. It was in no doubt that Dr Abdel Rahman had made a significant surgical error, that was both negligent and reckless. It took the view that the error was so significant that it was not easily remediable, and that further extensive training would need to take place for it to be remediated.

320. The Tribunal therefore took the initial view that Dr Abdel Rahman's surgical errors fell at the higher end of the spectrum of seriousness.

321. The Tribunal also considered whether there were any features about the allegation which may increase the seriousness further. It took into account the table set out at paragraph 36 of the Guidance. It considered the features relevant to Dr Abdel Rahman's case. It found evidence of a '*reckless disregard for patient safety'* and for the professional standards set out in GMP, particularly in relation to the expectation that Dr Abdel Rahman should have sought help from a consultant surgical colleague before the Procedure. The Tribunal reminded itself of its concerns that Dr Abdel Rahman '*attempted to hide or avoid taking responsibility'* for his errors, for example, asserting to Patient A's family that the Procedure was a success and refusing to countenance that he had made an error in the meeting with Mr F. This further undermined professional integrity and trust.

322. Taking these factors together, the Tribunal concluded that the surgical care concerns were now categorised at the very high end of the spectrum of seriousness.

323. The Tribunal then considered Dr Abdel Rahman's post-operative failings. It took the view that the surgical errors Dr Abdel Rahman had made were exacerbated by his failure to adequately respond to the post-operative warning signs, whilst maintaining to other professionals and the family that the Procedure had been a success.

324. The Tribunal again took into account paragraphs 28, 29, 30, and 31 of the Guidance which sets out the types of misconduct that may be considered at the lower, middle, or higher end of the spectrum of seriousness. It took the view that Dr Abdel Rahman's failings over a three-week period were particularly serious and were not easily remediable, because of the wide range and the nature of his failings which were both negligent and reckless.

325. The Tribunal therefore took the initial view that Dr Abdel Rahman's post-operative failings also fell at the higher end of the spectrum of seriousness.

326. The Tribunal identified some factors from the table at paragraph 36 in the Guidance that elevated the seriousness of the post-operative failings. It found that Dr Abdel Rahman's conduct demonstrated '*persistent*' shortcomings rather than isolated lapses, indicating a pattern of inadequate post-operative judgment. The Tribunal also determined that Dr Abdel Rahman again showed '*a reckless disregard for patient safety',* in particular by not seeking a second surgical opinion. In addition, Dr Abdel Rahman '*undermined collaborative working,'* contrary to the expectations set out in GMP.

327. Taking these factors together, the Tribunal concluded that the post-operative care concerns were now categorised at the very high end of the spectrum of seriousness, reflecting both the persistence of the failings and the significant risks posed to patient safety.

328. Next, the Tribunal considered the breach of the three IOT conditions. It was, again, assisted by the Guidance, but noted that there was not a 'case type' for this kind of misconduct, nor were there any examples listed in paragraphs 28 or 31.

329. In the table at paragraph 36 of the Guidance, the Tribunal noted that an aggravating aspect of this case is that Dr Abdel Rahman was '*undermining a system designed to protect the public.'* Dr Abdel Rahman had not complied with the requirements of his regulator. He had breached the three IOT conditions despite them having been imposed specifically to protect the public.

330. The Tribunal found that Dr Abdel Rahman's failure to comply with the IOT conditions undermined the regulatory system, which relies on practitioners adhering strictly to restrictions placed upon their practice. Although there was no evidence that Dr Abdel Rahman had failed to inform the relevant individuals at the Clinic of the IOT conditions, he had failed in his requirement to inform the GMC that he had done so. The Tribunal concluded that the breach represented a departure from the standards expected under GMP, particularly in relation to cooperation with regulatory processes.

331. The Tribunal decided that although the conduct did not reach the highest end of seriousness, it nonetheless represented a meaningful failure to comply with mandatory safeguards. The Tribunal therefore placed the breach at the medium level of seriousness within the regulatory spectrum.

332. The Tribunal considered whether Dr Abdel Rahman's actions in breaching the IOT conditions could be seen as '*premeditated behaviour'* which is also listed as a feature which

may increase the seriousness of the misconduct. It decided that there was no indication why Dr Abdel Rahman had failed to inform the GMC that he had started work, and the Tribunal accepted that he made contact with the GMC two weeks later on his own initiative. The Tribunal was not satisfied that premeditation could be established in this case.

333. Lastly, the Tribunal considered Dr Abdel Rahman's act of dishonesty. It reminded itself that Dr Abdel Rahman had lied to the GMC when he sent an email stating that he had started work *'that week'* when he had in fact started some 12 days earlier.

334. The Tribunal considered the Guidance. It noted that allegations usually falling at the lower end of the spectrum of seriousness and which due to their nature are more likely to be easily remedial in relation to dishonesty concerns, could be;

> *'an incident of dishonest behaviour which is limited in nature and had limited impact, such as where it occurred outside of the doctor's professional role and the value of any financial benefit derived was low.'*

335. In contrast, the Tribunal noted that allegations that are likely to fall at the high end of the spectrum of seriousness, in relation to acts of dishonesty could be;

> *'dishonesty, other than where it occurred outside of the doctor's professional role and was not persistent or repeated, and the value or other benefit derived was not significant.'*

336. The Tribunal acknowledged that dishonesty is categorised as serious and accepted the established caselaw. The act of dishonesty was committed as part of Dr Abdel Rahman's professional life. It therefore determined that Dr Abdel Rahman's misconduct began at the higher level of seriousness.

337. The Tribunal accepted that the act of dishonesty was limited in nature and was not repeated or persistent. It also accepted that Dr Abdel Rahman had made the first contact with the GMC to give his employment details. However, it decided that there were a number of features of concern; the dishonesty was directed at his regulator and was an attempt to cover up the fact that he had breached conditions that had been put in place to protect the public. The Tribunal again noted the table set out in paragraph 36 and concluded that Dr Abdel Rahman was '*undermining a system designed to protect the public,'* by not being

truthful to his regulator. This is a feature that increased the seriousness of this aspect of misconduct.

338. The Tribunal decided that acts of dishonesty by their nature have an element of '*premeditated behaviour,'* but accepted that Dr Abdel Rahman's actions were limited in scope. It was mindful however, that dishonesty is serious and has the potential to undermine the confidence that the public holds in the medical profession. It concluded therefore Dr Abdel Rahman's act of dishonesty fell at the higher end of the spectrum of seriousness.

339. In summary, the Tribunal concluded that Dr Abdel Rahman's clinical failings both during and after the Procedure fell at the very high end of the spectrum of seriousness. It concluded that the IOT breach fell at the mid-range of the spectrum of seriousness. It decided that the act of dishonesty fell at the higher end of the spectrum of seriousness.

340. This meant that the Tribunal's starting point for assessing current and ongoing risk to public protection is high.

Step 2c- consider the impact of any relevant context

341. The Tribunal had regard to the context surrounding the Allegation, and considered whether this had any effect on its assessment that the misconduct was at the higher end of the spectrum of seriousness. In doing so, the Tribunal considered whether there was any work environment context, role and experience, or personal context which might have an impact on the assessment of whether Dr Abdel Rahman poses a current and ongoing risk to public protection.

342. So far as the clinical findings are concerned, the Tribunal noted that Dr Abdel Rahman was working as a locum at the time of these events and was not on the specialist register. There was a suggestion in the documents that he was new to the Hospital. The Tribunal was also aware that both the Procedure and the post-operative care had taken place during the COVID-19 pandemic. This is likely to have meant that there were workload pressures at the Hospital.

343. The Tribunal also accepted Mr C's opinion that Dr Abdel Rahman was faced with an '*extremely difficult procedure,'* because of Patient A's complex medical history, and the presence of the tumour.

344. The Tribunal also noted from the Trust report that the Hospital conceded that there was '*an absence of an organisational framework that guides the practices, supervision or mentoring of locum surgeons.'* It looked as if the Hospital had not therefore provided Dr Abdel Rahman with a good quality induction package.

345. The Tribunal concluded therefore that there were a number of issues relating to Dr Abdel Ramhan's role and experience, as well as the working environment that it needed to consider.

346. However, having considered this matter carefully, the Tribunal took the view, that faced with this situation, Dr Abdel Rahman could and should have sought assistance from a consultant surgical colleague. Mr C made it clear in his evidence that sharing difficult problems is expected in everyday practice. He said that *'the vast majority of consultants would have sought advice.'* In his expert report, Mr C said;

> *'I accept that this will have been an extremely difficult procedure due to Patient A's previous surgery and the Fe mass of tumour. If Dr YAR* [Dr Abdel Rahman] *had realised the potential difficulties when he commenced Patient A's operation on 15/08/2020* [sic] *he should have tried to get help from a colleague either at his own Trust or from another Consultant at the Regional Specialist Upper Gastro-intestinal Surgical Centre.'*

347. The Tribunal noted that there is no evidence that Dr Abdel Rahman had tried to overcome these contextual factors, and it concluded that they should not have been allowed to affect the care of Patient A. It was of the view that Dr Abdel Rahman had acted recklessly and put Patient A at a high risk of harm. The Tribunal took the view that faced with the situation he found himself in, Dr Abdel Rahman should clearly have sought advice both before the Procedure and for Patient A's care post-operatively.

348. The Tribunal was not aware of any contextual factors that affected Dr Abdel Rahman's actions so far as the IOT breaches and the act of dishonesty were concerned. He had been informed or the IOT conditions just two months before he breached them and they were clear. The Tribunal could not see any working environment or issues of experience that could affect the seriousness of his actions in this respect.

349. Due to Dr Abdel Rahman's absence at the hearing, the Tribunal had no personal circumstances that it could take into account.

350. Accordingly, the Tribunal concluded that there was no relevant context that impacted on its initial assessment of either the seriousness of the allegations, or its initial assessment of the risk that Dr Abdel Rahman poses to public protection.

Step 2d- consider how the doctor has responded to the allegations.

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

Insight

352. The Tribunal firstly looked to see if there was any evidence of insight. It wanted to see if Dr Abdel Rahman understood what had happened and would accept how he could act differently in future.

353. The Tribunal firstly noted that Dr Abdel Rahman had initially cooperated with the GMC during its investigation and had submitted a Rule 7 response. He had also cooperated with the Trust investigation and provided a statement. In both, it is clear that he was denying the clinical allegations.

354. Since the service of the Notice of Allegation and the evidence bundle, Dr Abdel Rahman has not engaged with the Tribunal process. He did not attend the Tribunal hearing and denials to the paragraphs of the Allegation were entered on his behalf.

355. The Tribunal accepted that a doctor is entitled to deny allegations or indeed not respond to them. However, the lack of response, and Dr Abdel Rahman's absence from the hearing meant that the Tribunal did not have the benefit of any evidence of insight from him.

356. The Tribunal also accepted that Dr Abdel Rahman is entitled to set out his denials in a statement or Rule 7 response. However, it was concerned about the way he approached his defence, which was by blaming and criticising others. His tone in his responses was challenging and accusatory. He refused to accept the expert findings and made repeated assertions that demonstrate a complete refusal to recognise any potential issues with his conduct. He was critical of the GMC investigation, terming it *'a witch hunt.'*

357. The Tribunal firstly considered the evidence it had taken into account at stage one of these proceedings. The Tribunal noted that Dr Abdel Rahman was dismissive of concerns that were raised about Patient A's wellbeing after the Procedure. He also met with Patient A's parents and told them that the Procedure had been successful and that Patient A would be

discharged from the Hospital soon. Even after the second procedure had taken place, faced with the evidence that Mr D, Mr E and Mr F had seen, Dr Abdel Rahman refused to acknowledge that he had made a surgical error, even when Mr F met with him on 18 September 2020.

358. The Tribunal was concerned that Dr Abdel Rahman's behaviour after both the Procedure and then the second corrective procedure demonstrates a marked lack of insight at that time.

359. The Tribunal had seen no contemporaneous or subsequent evidence of remorse, empathy, or recognition of the impact on Patient A and his family. It saw no attempt at an apology.

360. The Tribunal then considered Dr Abdel Rahman's Trust statement and his Rule 7 response.

361. Dr Abdel Rahman explained that he had conducted the Procedure correctly, and that Mr D '*has kept assuming his own facts.'* He said that it *'All sounds strange and weird to me'* that Mr D had not contacted him to join him in theatre for the second procedure. He said that Mr D chose two work colleagues to join him who then give accounts that supported him. He said that Mr D had failed to understand what he saw and had made a mistake about there being a closed loop. He said;

> *'-It is clear that, Mr. D has a lot of difficulties and confusions identifying the proper anatomy in this complex case. His misinterpretation has driven him into unnecessary colonic and small bowel resection.'*
>
> …
>
> *'I do believe that if Mr. D has discussed the case beforehand with me or has called me during the operation, it could save him a lot of difficulties and confusions, and of course, would offer a better outcome.'*
>
> ….
>
> *'We will examine the lies put forth by Mr D about his alleged surgical findings on 16/09/2020. By the end, we can show Mr D to be deceitful and untrustworthy.'*

362. The Tribunal noted that Dr Abdel Rahman claimed that Mr D's actions were; '*the reason that Patient A had to have a high output stoma and a colostomy. It is also the reason that Patient A would stay in hospital indefinitely.'*

363. In his responses, Dr Abdel Rahman also criticised the GMC expert, Mr C. He stated that he had a conflict of interest because of his (apparent) working relationship with Mr D. He said that Mr C did not have the evidence before him when he drafted his first report in order to make the conclusions that he did, and that he had relied on the accounts of others. He said that Mr C then demonstrated bias by '*working backwards'* in order to conclude that Dr Abdel Rahman was to blame. He said that Mr C had a *'disregard for any evidence that supports Mr Rahman's claims,'* and that he demonstrated '*A pattern of behaviour that will show Mr. C time and time again, refusing to examine evidence presented by Mr Rahman as well as failing to highlight clear contradictions to the narrative he has concluded upon.'* He accused Mr C of *'leading a witch hunt.'*

364. The Tribunal noted some examples of Dr Abdel Rahman's criticism of Mr C in his Rule 7 response. He said;

> *'Mr C's approach to the investigation will be shown to not only be consistently biased, but negligent and inattentive.'*
> …
> *'Mr C's utter failure to critically reflect upon these statements is only symptom of his inadequacy as a so called "Expert" in this case.'*

365. The Tribunal noted that Dr Abdel Rahman also criticised Professor B in a similar vein. He said;

> *'Mr [B]'s approach to investigating this case was similar to that of Mr C. He is only interested in attempting to prove the already falsely established narrative. His opinion can easily be disregarded as inadequate. It is clear that the GMC instructed him not to investigate the case but instead guided him to reach the same conclusion they already agreed upon.'*

366. Dr Abdel Rahman did not accept the legitimacy of the Trust Investigation, stating that he was being treated as *'a scapegoat'*. He also expressed concern about the GMC investigation. He said; '*Personally, I could've never imagined the GMC's process to be so ripe with blatant bias.'* He said;

'The actions of the staff at Royal Oldham Hospital can only be described as malicious. The ward staff, the nurses, the consultants and the clinical director. All of whom, when faced with serious questions about Patient A's treatment at their hospital are unable to respond except by pointing the finger at Mr Rahman. … The environment created by the staff at Royal Oldham hospital was one of passing the blame, of any and all complications arising during Patient A's treatment and simply twisting the words to make it seem as though Mr Rahman was to blame for all of it.'

…

'[Sister G], and her colleagues inserted themselves in between Patient A's parents and Mr Rahman. Rather than explaining the difficulties Mr Rahman faced in communicating with them during such unprecedented times. They instead instructed Patient A's parents to be harsh on Mr Rahman. They convinced Patient A's parents that any and all problems are the fault of Mr Rahman.'

367. The Tribunal had regard to paragraph 93 of the Guidance which sets out some circumstances where it might be reasonable for a Tribunal to conclude that a doctor lacks any insight. One of the circumstances is where they have '*provided an explanation after the event in which they have tried to minimise their own role or culpability or otherwise sought to blame others.'*

368. The Tribunal decided that Dr Abdel Rahman had not accepted responsibility for his actions and had sought to blame Mr D. He had then criticised the experts, the Trust, and the GMC for the outcome of the subsequent investigations. It concluded that this demonstrated a marked lack of insight in relation to the clinical allegations.

369. The Tribunal noted that it received no response from Dr Abdel Rahman regarding the breach of IOT conditions or the dishonesty allegation. It follows, therefore, that it concluded that there is no evidence of insight in regard to this aspect of the Allegation.

370. The Tribunal concluded that Dr Abdel Rahman had not accepted any responsibility, had shown no reflection, no remorse, and no accountability for his actions.

371. The Tribunal decided that it had not received any evidence of insight in Dr Abdel Rahman's case for any part of the Allegation.

Remediation and risk of repetition

372. The Tribunal firstly considered whether Dr Abdel Rahman's actions were remediable.

373. The Tribunal reminded itself that Mr C had described the Procedure that Dr Abdel Rahman carried out as being '*at the extreme end of surgical error,'* and stated that *'it is as bad as it gets for a consultant surgeon'.* He said that the Procedure conducted was *'not known to man.'* It took from this opinion that there would need to be a great deal of insight and retraining before Dr Abdel Rahman could practise again, because of the high risk of harm to other patients. It concluded that such an extreme error is difficult to remediate but that it might be possible through participation in extensive training, supervision, coaching and/or mentoring and then putting that learning into practice.

374. Secondly, the Tribunal recognised that dishonesty is generally held to be difficult to remediate and reminded itself of the case of *Nkomo* (above). It accepted that, unlike with clinical errors, where further practice and/or teaching could show a doctor the correct method of practice, the nature of dishonest behaviour goes more to their character than learning.

375. The Tribunal decided therefore that all Dr Abdel Rahman's actions were difficult to remediate but considered that it was possible. It then moved on to consider what steps he had taken to remediate.

376. The Tribunal had not received any evidence at this stage of the hearing from Dr Abdel Rahman. It did not know if he had attended any courses relating to either clinical performance or behaviour. It had not received any objective evidence of remediation either. There were no testimonials, nor a statement from a responsible officer.

377. The Tribunal concluded that there was no evidence of any steps taken to remediate in this case.

378. The Tribunal decided that the lack of evidence of either insight or subsequent remedial steps demonstrated that there remained a high risk of repetition in Dr Abdel Rahman's case.

379. Moreover, the Tribunal found no evidence that Dr Abdel Rahman had taken steps to maintain his knowledge and skills since the events in question. There was no indication of what he had been doing professionally, clinically, or educationally in the intervening period. This absence of evidence further contributed to the Tribunal's concerns regarding the risk of repetition.

380. In summary, the Tribunal found no evidence, when considering how Dr Abdel Rahman has responded to the Allegation, to change its view of the seriousness of his misconduct.

Step 2e on the basis of the conclusions reached in steps 2b, 2c and 2d decided if the doctor poses any current and ongoing risk to public protection and make a finding of impairment.

381. The Tribunal then considered whether, on the basis of the conclusions reached in steps 2b, 2c, and 2d, Dr Abdel Rahman poses any current and ongoing risk to public protection.

382. At step 2b, the Tribunal concluded that both Dr Abdel Rahman's clinical failings and dishonest behaviour fell at the higher end of the spectrum of seriousness, with the breach of IOT conditions being in the mid-range. Its start point was that Dr Abdel Rahman poses a high risk to public protection.

383. At step 2c, the Tribunal found no contextual factors for it to change that view.

384. At step 2d, the Tribunal reassessed the risk and decided that it is high for all aspects of the misconduct, including the breach of the IOT conditions, due to the marked lack of insight and the absence of any remediation.

385. Considering the above findings, the Tribunal was satisfied that Dr Abdel Rahman poses a current and ongoing risk to public protection by reason of his misconduct. It considered the risk to be high.

386. In relation to the first limb of public protection, protecting the health, safety and wellbeing of the public, the Tribunal bore in mind that this was a case involving a significant clinical failure and inadequate post-operative care of Patient A. Without having demonstrated any developments to his insight or evidence of remediation, the Tribunal was satisfied that actions of this nature compromised patient safety. It was not assured, that if similar circumstances presented themselves in the future, that the risk had been eliminated.

387. As to the second limb, maintaining public confidence in the medical profession, the Tribunal concluded that a fully informed and reasonable member of the public would be seriously concerned if a doctor who had not accepted accountability for serious clinical failings of this nature, and had gone on to breach his IOT conditions and been dishonest, was

permitted to practise without restriction. The Tribunal considered that not putting any restrictions in place would undermine confidence in the profession.

388. In relation to the third limb, maintaining proper professional standards and conduct, the Tribunal found that Dr Abdel Rahman had failed to uphold the standards required of doctors within the medical profession. He had breached a number of paragraphs of GMP.

389. The Tribunal then considered the features set out in the case of *Grant.* It concluded that Dr Abdel Rahman's actions put Patient A at risk of harm, and had both brought the medical profession into disrepute, and breached one of the fundamental tenets of the medical profession. He had also acted dishonestly. Due to the lack of evidence of insight and remediation, the Tribunal concluded that there was an ongoing high risk that he could repeat these failings in future.

390. In light of this, and its finding that there was no evidence of insight or remediation, the Tribunal determined that a finding of impairment was necessary to maintain the health, safety, and well-being of the public, maintain public confidence in the profession, and uphold proper professional standards.

391. The Tribunal concluded that Dr Abdel Rahman currently poses a high level of ongoing risk to all three limbs of public protection.

392. Accordingly, the Tribunal determined that Dr Abdel Rahman's fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 22/07/2026

393. This determination was handed down in public.

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

The Evidence

395. The Tribunal took into account the evidence it had received during the facts stage of the hearing where relevant to reaching a decision on sanction. No further evidence was received at this stage.

396. The Tribunal reviewed its findings at the facts and impairment stages.

Submissions

On behalf of the GMC

397. Mr Donoghue stated that Part C of the 'Guidance for MPTS Tribunals' (the Guidance') sets out the approach to be followed at this stage of proceedings. He pointed to the relevant paragraphs of Part C, which describe the approach that the Tribunal should take, and the sanctions available to it.

398. Mr Donoghue submitted that only a sanction of erasure could adequately reflect the seriousness of this case and achieve public protection.

399. Mr Donoghue then directed the Tribunal to the sanction bandings set out at paragraph 62 of Part C, which he stated provided a useful starting point and guide. He submitted that both the surgical and post-operative care of Patient A fell at the very highest end of seriousness, placing it at the top of the banding for *clinical concerns,* where suspension of six months up to erasure is indicated.

400. Mr Donoghue stated that the breach of IOT conditions should be considered under the banding for *Misconduct arising from breach of court sanctions and determinations by other regulatory bodies.* He reminded the Tribunal that it had found that the breach of the IOT conditions fell within the medium range of seriousness, which indicated a banding of suspension for six to twelve months.

401. Mr Donoghue stated that Dr Abdel Rahman's dishonesty was found by the Tribunal to be at the higher end of seriousness, therefore within the *dishonesty* banding that ranges from nine months suspension to erasure.

402. Mr Donoghue submitted that three of the areas of misconduct fall at the upper end of seriousness in categories where erasure is an available sanction and the fourth still attracts a significant period of suspension.

403. Mr Donoghue submitted that the Tribunal's prevailing consideration must be the overall risk to public protection arising from the totality of Dr Abdel Rahman's conduct. He said it should be viewed in the context of the multiple and serious areas of misconduct found proved. He reminded the Tribunal that it had already determined that Dr Abdel Rahman posed a high ongoing risk to all three limbs of public protection.

404. Mr Donoghue then went through the sanctions available to the Tribunal.

405. Mr Donoghue submitted, firstly, that taking no action would not be justified. He relied on paragraphs 13-15 of Part C, which states that taking no action is only justified in exceptional circumstances, and submitted that no such circumstances exist, particularly given the seriousness of the misconduct and Dr Abdel Rahman's lack of engagement or insight.

406. Mr Donoghue then submitted that conditions would not be appropriate. He drew the Tribunal's attention to paragraphs 21 -27 of Part C which make clear that conditions must be appropriate, workable and measurable. He also referred to paragraph 28 which provides some examples where conditions may be a suitable sanction. However, he submitted that there is no evidence that Dr Abdel Rahman is willing and/or able to remediate, and there is strong evidence that he would not comply with any conditions imposed. In any event, he submitted that conditions would not appropriately protect and promote the three limbs of public protection, given the seriousness of the matters found proved.

407. Turning to suspension, Mr Donoghue submitted that this sanction would also be insufficient. He pointed to paragraph 45 of Part C which sets out some of the factors where a tribunal might find that suspension is an appropriate sanction. However, he submitted that this is not a case where a period of time would allow Dr Abdel Rahman to gain insight and remediate his actions, as he has demonstrated that he does not wish to engage with the GMC or tribunal process. Neither had he demonstrated any insight into the matters now before the Tribunal.

408. Mr Donoghue stated there are issues of patient safety which arise in this case given the significant clinical failings and Dr Abdel Rahman's refusal to recognise any shortfalls in his care and treatment. Moreover, he argued that suspension is intended for cases where a doctor may safely return to practice after gaining insight or remediating any of his failings. He submitted that Dr Abdel Rahman has shown no willingness to engage or remediate and that a period of suspension would not reduce the risk he poses. Mr Donoghue submitted that

suspension would fail to maintain public confidence or uphold professional standards, given the gravity and multiplicity of the misconduct.

409. Mr Donoghue submitted that erasure is the only proportionate sanction. He relied on the Guidance. It states that erasure is appropriate where behaviour or performance is incompatible with continued registration, where serious harm has occurred and cannot be mitigated by lesser sanctions, where there is persistent lack of insight, and where continued registration would undermine public confidence.

410. Mr Donoghue submitted that all these factors are present in Dr Abdel Rahman's case. He emphasised that Patient A had suffered serious harm, and that the risk of repetition is high. He stated that Dr Abdel Rahman also breached conditions designed to protect the public, and that his dishonesty and lack of engagement significantly undermine confidence in the profession.

411. In summary, Mr Donoghue submitted that erasure is the only sanction in this case which can sufficiently achieve the necessary level of public protection.

The Tribunal's Determination on Sanction

412. The Tribunal had regard to the three limbs of public protection throughout its deliberations. It considered the submissions made by Mr Donoghue. It was reminded by the LQC that the procedure to be adopted was under the Guidance at Section three - Part C. Also, the Tribunal took into account the General Introduction of the Guidance and the relevant case types for this case. It noted that the Guidance was not statutory but was an authoritative steer.

413. The Tribunal considered the impact of any specific sanction on Dr Abdel Rahman. It took into account Dr Abdel Rahman's hitherto good character throughout its deliberations. It noted in his Rule 7 response that he stated *'30 Years of an unblemished record. Without a single complaint. Ever.'* The Tribunal did not have the benefit of any references or testimonials.

414. However, the Tribunal was mindful of the fact that Dr Abdel Rahman was facing a finding of dishonesty. It considered the case of *Nicholas-Pillai v GMC* [2009] EWHC 1048 which summarised how seriously dishonesty is viewed in medical practitioners. It noted that

the case states that *'…sanction will often and perfectly properly be the sanction of erasure, even in the case of a one-off instance of dishonesty.'*

415. The Tribunal then reminded itself of its findings at both the facts and impairment stages.

416. At the facts stage, the Tribunal found a number of different aspects of misconduct proved.

417. The Tribunal had found that Dr Abdel Rahman failed to seek assistance from a surgical colleague with the management of Patient A's care before operating on him, then made two significant surgical errors during the Procedure. After the Procedure, Dr Abdel Rahman failed to adequately respond to a number of warning signs about Patient A's recovery over a three-week period. Dr Abdel Rahman did not seek a second surgical opinion and did not heed the concerns of others. He also stated that the Procedure had been a success to Patient A's family, when both the clinical and radiological evidence did not support this.

418. The Tribunal also found that Dr Abdel Rahman breached three IOT conditions that had been imposed on him pending this hearing. When he later wrote to the GMC about the post he had secured, he was dishonest about his start date.

419. At the impairment stage, the Tribunal considered the seriousness of the findings that it had found proved, and the risk that Dr Abdel Rahman posed to the three limbs of public protection.

420. The Tribunal concluded that Dr Abdel Rahman's clinical failings both during the Procedure and after were at the very high end of the spectrum of seriousness. It was particularly concerned that Mr C had stated that Dr Abdel Rahman's Procedure was '*not compatible with life'* and Patient A would have died had Mr D not carried out corrective surgery. It also concluded that the dishonest act was at the higher end, and the breach of the IOT fell at the mid-range of the spectrum of seriousness.

421. The Tribunal had noted that there was a marked lack of insight and remediation in this case, and it concluded therefore that Dr Abdel Rahman posed a high risk to all three limbs of public protection in relation to all aspects of the misconduct.

422. Bearing in mind its findings at the facts and impairment stage, the Tribunal then considered the Guidance and looked at the table at paragraph 62 of Part C which sets out the sanctions bandings for certain case types. This table categorises the indicative sanctions according to level of risk to public protection. It noted that Dr Abdel Rahman's misconduct fell within three different case types, and it had decided he posed high level of risk to public protection in relation to them all.

423. The Tribunal concluded therefore that the provisional view on sanctions would lead it to consider '*suspension 6 months to erasure'* for the clinical findings and '*9 months to erasure'* for the act of dishonesty.

424. The Tribunal considered whether the breach of the IOT conditions fell within *'Convictions, cautions, misconduct arising from breach of court sanctions and determinations by other regulatory bodies',* and/or case type 8 '*Criminal convictions, cautions, court sanctions and determination by another body responsible for the regulation of a health or social care profession'.* Although a breach of IOT conditions is not a determination, the indicative sanctions banding and case type 8 appeared to be relevant and helpful in this case. It concluded that, although it had found that Dr Abdel Rahman's actions fell within the mid-range on the spectrum of seriousness, he posed a high level of risk to public protection for this aspect of misconduct too, because of the lack of insight and remediation. It concluded, therefore, that it should be considering '*Suspension 12 months to Erasure.'*

425. The Tribunal was aware that the sanctions bandings are guidance only and that sanction is a matter for the Tribunal, with each case considered on its own facts and merits. The Tribunal decided that its main concern in this case was the significant surgical errors that were made during the Procedure, along with the persistent failings during a three-week post-operative period. These were aggravated by the marked lack of insight and remediation.

426. The Tribunal took the view that the breach of the IOT conditions and the act of dishonesty formed part of a pattern of conduct demonstrating Dr Abdel Rahman's marked lack of insight and lack of engagement with any recent regulatory process.

427. The Tribunal was also aware that it should consider this case in its entirety and impose only one sanction.

428. The Tribunal then considered the least restrictive action first.

No action

429. The Tribunal first considered whether to conclude the case by taking no action. It noted paragraph 13 of the Guidance;

> *'13. Where a doctor's fitness to practise is impaired, it will usually be necessary for the MPT to restrict the doctor's registration to achieve public protection. But there may be exceptional circumstances to justify an MPT taking no action. Exceptional circumstances are unusual, special, or uncommon, so such cases are likely to be very rare.'*

430. The Tribunal determined that there were no exceptional circumstances which would warrant the taking of no action, particularly in the context of the facts found proved and the Tribunal's determination on impairment. It considered that taking no action would not be proportionate, or sufficient to protect the public, or reflect the seriousness of its findings.

Conditions

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

432. The Tribunal noted that at paragraph 23 of Part C it states that conditions are likely to be workable where;

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

433. The Tribunal took into account the fact that Dr Abdel Rahman had demonstrated a marked lack of insight in relation to his clinical failings and there was no evidence of insight in relation to the breach of IOT conditions or dishonesty.

434. The Tribunal was not satisfied that Dr Abdel Rahman would be willing to remediate his actions or comply with any conditions. He had not engaged with the Tribunal process and had been very critical of the GMC investigation. He had already breached three of the conditions that the IOT had imposed on him prior to this hearing.

435. The Tribunal concluded therefore that conditions would not be workable in this case.

436. The Tribunal took the view that neither would conditions be appropriate. It decided that no conditions could address the specific findings about the current and ongoing risk to public protection posed by Dr Abdel Rahman. The clinical failings were significant. Further, an act of dishonesty goes more to character than learning or supervision. It would be difficult to remedy this misconduct through the imposition of conditions.

437. The Tribunal also considered whether conditions might be a proportionate sanction in this case. In doing so, it had regard to paragraph 28 of part C which states that;

> *28. Conditions may be proportionate in cases where the doctor has shown a degree of insight into the allegation and some, or all, of the following factors are present;*
>
> *a. the doctor has demonstrated they are willing and/or able to remediate*
> *b. identifiable areas of the doctor's practice need prohibiting, monitoring, or retraining*
> *c. the doctor has demonstrated they are willing to be open and honest with patients and others they work with if things go wrong*
> *d. the doctor will not put patients at harm, either directly or indirectly, by having conditions on their registration.*

438. The Tribunal had already concluded that Dr Abdel Rahman had demonstrated a marked lack of insight. He had not demonstrated any willingness to remediate his clinical failings despite having had almost six years to do so. It felt that patients would still be at high risk of harm were Dr Abdel Rahman allowed to return to practise, even if restricted by conditions.

439. The Tribunal was mindful of paragraph 30 of Part C which states that;

> *Conditions are unlikely to be a proportionate response in cases where the nature of the allegations about the doctor's behaviour fall at the higher end of the spectrum of seriousness and/or suggest an underlying problem with their attitude.*

440. The Tribunal also took into account the Guidance Introduction case type 5 which relates to clinical concerns and noted paragraph 76 which reads;

> *Suspension or removal are only likely to be needed where the assessment of risk is high based on the case falling at the higher end of the spectrum of seriousness, there being relevant context known about the doctor and/or their working environment that increases risk and/or because the doctor has shown a lack of insight and/or is not willing or able to remediate.*

441. The Tribunal also considered case type 2 in the Guidance Introduction which relates to dishonesty. Paragraph 97 of that section states that *where the level of current and ongoing risk to public protection is medium or high, this will require consideration of suspension or erasure.*

442. Considering the Guidance as a whole, due to the serious nature of the misconduct, the Tribunal concluded that conditions would not be a proportionate response, and suspension and erasure should be considered.

443. In summary, the Tribunal decided that conditions were not workable, measurable, appropriate or proportionate. There was no evidence Dr Abdel Rahman would comply with any conditions, especially when considering the breach of his previous IOT conditions. Dr Abdel Rahman had not shown any insight or willingness to remediate his actions. This was misconduct at the higher end of seriousness and conditions would not meet the requirements of public protection.

444. The Tribunal was also of the view that a fully informed member of the public would not regard the imposition of conditions appropriate in this case, due to the significant clinical failings and the subsequent act of dishonesty.

Suspension

445. The Tribunal went on to consider whether to suspend Dr Abdel Rahman's registration. It was aware that a sanction of suspension was within the range it might consider according to the sanction bandings set out above.

446. The Tribunal was aware that suspension is intended to address the level of current and ongoing risk to public protection and is not intended to be punitive. It noted that suspension can also have a deterrent effect and be used to send a signal to the doctor, the profession and the public about what is regarded as behaviour unbefitting a registered doctor.

447. The Tribunal considered paragraph 45 of Part C which states that suspension may be proportionate in cases where some, or all, of the following factors are present:

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

448. The Tribunal had already concluded that conditions were not appropriate, measurable, and workable in Dr Abdel Rahman's case, as set out above and so *a* above could apply in this case.

449. However, the Tribunal was aware that Dr Abdel Rahman had not demonstrated any insight and had made no attempts to remediate his actions. The Tribunal could not be satisfied therefore that he would '*gain insight into any deficiencies or remediate'* even if he was given time during a period of suspension. It decided therefore that *b* above did not apply.

450. The Tribunal felt that the level of risk that Dr Abdel Rahman poses to the public remains significant. His clinical failings had caused serious harm to Patient A. Mr C's view is that Patient A would have died had the second surgery not taken place. The Tribunal was particularly concerned that, over a three-week period, Dr Abdel Rahman failed adequately to respond to warning signs and, when his errors during the Procedure were discovered, refused to accept that they had occurred. He has not remediated his failings. The Tribunal decided that patient safety remains an issue.

451. Moreover, the Tribunal concluded that, given the serious and multiple findings of misconduct against Dr Abdel Rahman, this is a case where a sanction of suspension would not adequately maintain public confidence in the profession and/or maintain professional standards. It decided therefore that *c* above did not apply.

452. In summary, the Tribunal concluded that a period of suspension would not be appropriate or proportionate in this case.

Erasure

453. The Tribunal therefore considered erasure. It considered Part C of Guidance at paragraphs 55 -59 carefully.

454. The Tribunal noted that erasure takes away a doctor's registration and is used to protect the public in the most serious cases. It also has a deterrent effect as it sends a signal to the individual doctor, the profession and the public about what is regarded as behaviour unbefitting a registered doctor.

455. The Tribunal noted paragraph 57 of the Guidance which outlines where erasure might be the proportionate response. They are where;

> *a. conditions are not appropriate, measurable and/or workable and suspension is not sufficient to protect the public*
> *b. the doctor's behaviour or performance is such that it caused serious harm, and the risk of harm recurring cannot be mitigated sufficiently through putting conditions or suspension in place*
> *c. the doctor has shown a persistent lack of insight into the seriousness of the allegation about their behaviour or performance and the potential or actual consequences, and/or*
> *d. the seriousness of the facts found proven and/or impact of any relevant context that increased the current and ongoing risk to public protection mean the effect of the doctor continuing to hold registration is such that it will undermine public confidence in the profession.*

456. The Tribunal considered that all of paragraph 57 was applicable in this case. It decided that conditions were not appropriate and suspension is not sufficient to protect the public from the high risk of harm that Dr Abdel Rahman still poses. Dr Abdel Rahman has shown a

persistent lack of insight into the seriousness of the Allegation and the effect on Patient A. His actions undermine public confidence in the profession and the maintenance of proper professional standards and conduct.

457. The Tribunal took the view that this was a very serious case. The surgical errors were significant, and the post-operative care exacerbated the surgical failings. The subsequent breach of IOT conditions and associated act of dishonesty were further aggravating features of this case.

458. The Tribunal concluded that Dr Abdel Rahman's misconduct is fundamentally incompatible with continued registration.

459. The Tribunal therefore determined that the only appropriate and proportionate sanction which would uphold all three limbs of public protection in this case was the sanction of erasure.

460. The Tribunal was also of the view, that a member of the public, informed of this case, would expect a sanction of erasure to be imposed.

461. Accordingly, the Tribunal determined to direct that Dr Abdel Rahman's name be erased from the Medical Register.

Determination on Immediate Order - 22/07/2026

462. This determination was handed down in public.

463. Having determined to erase Dr Abdel Rahman'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

On behalf of the GMC

464. Mr Donoghue submitted that an immediate order was necessary in this case. He referred the Tribunal to the Guidance in Part C, particularly paragraphs 79 to 86 which

directed the Tribunal to consider whether such action is required to protect the public, uphold the public interest, or act in the doctor's own interests. He emphasised that where erasure is the substantive sanction, the only available immediate measure is suspension.

465. Mr Donoghue submitted that the findings against Dr Abdel Rahman of serious surgical and post-operative failings, dishonesty at the high end of seriousness, and breach of interim conditions, collectively demonstrated a high risk to public protection, particularly in light of the doctor's lack of insight or remediation.

466. Mr Donoghue relied on paragraph 84 of the Guidance, submitting that all three limbs are engaged as Dr Rahman poses a risk to patient safety, the risk across all the components of public protection is high, and immediate action is required to maintain public confidence. He therefore invited the Tribunal to impose an immediate order of suspension and revoke the existing interim order of conditions.

The Tribunal's Determination

467. The Tribunal considered that it may impose an immediate order if it is necessary for the protection of members of the public or is otherwise in the public interest. The decision whether to impose an immediate order is at the discretion of the Tribunal, based on the facts of the case.

468. The Tribunal noted the Guidance at Part C. It paid particular regard to paragraphs 79 and 83 of Part C which provide;

> *79 The MPT may impose an immediate order where 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…*
> *…*
>
> *84 It will not usually be appropriate for a doctor to hold unrestricted registration until a sanction takes effect in cases where:*
>
> *a the doctor poses a risk to patient safety*
> *b the risk to one or more parts of public protection is high, and/or*
> *c immediate action is needed to maintain public confidence in the medical profession.*

469. The Tribunal has already concluded that Dr Abdel Rahman made significant surgical errors and failed in his clinical care to Patient A over a three-week period thereafter. He has

shown no insight nor remediated his actions. The Tribunal was satisfied therefore that Dr Abdel Rahman poses a significant risk to patient safety.

470. The Tribunal also took the view that Dr Abdel Rahman's misconduct undermines public confidence and does not uphold proper professional standards.

471. Lastly, the Tribunal decided that a fully informed member of the public would not expect Dr Abdel Rahman to be allowed to continue in unrestricted practice, having been erased from the register for such serious misconduct.

472. In summary, the Tribunal was satisfied that all of the factors set out in paragraph 84 were present.

473. This means that Dr Abdel Rahman's registration will be suspended from the date on which notification of this decision is deemed to have been served upon him. The substantive direction, as already announced, will take effect 28 days from that date, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

474. Any interim order currently in place on Dr Abdel Rahman's registration will be revoked when the immediate order takes effect.

ANNEX A – 06/07/2026

Service and Proceeding in Absence

475. Dr Abdel Rahman was neither present nor legally represented at this hearing. The Tribunal noted that in order to proceed with the hearing in Dr Abdel Rahman's absence, it needed to be satisfied that he had been properly served with the Notice of Hearing (NoH) and whether it was appropriate for the hearing to proceed in his absence.

476. The Tribunal was provided with a copy of a service bundle from the General Medical Council (GMC). This included a screenshot of Dr Abdel Rahman's email address and registered address. On 28 May 2026, the MPTS sent the NoH letter to Dr Abdel Rahman at his registered address, via Special Delivery, indicating that his case was due to be heard today, 6 July 2026, and enclosing a draft copy of the hearing bundle. This letter was delivered and Dr Abdel Rahman signed for it on 3 June 2026.

477. The Tribunal also noted the same NoH Letter was sent to Dr Abdel Rahman by the MPTS by First Class Post dated 28 May 2026 and by email to the email address recorded by the GMC.

478. The GMC also sent the notice of allegation (NoA) letter to Dr Abdel Rahman on 28 May 2026.

479. To date no response has been received from Dr Abdel Rahman.

Submissions

<u>On behalf of the GMC</u>

480. Mr Ryan Donoghue took the Tribunal through the requirements set out under the (Fitness to Practise) Rules 2004, as amended ('the Rules') and the Medical Act.

481. Mr Donoghue then referred to the service bundle and highlighted that the NoH letter had been sent to Dr Abdel Rahman by First Class post, Special Delivery and to his email.

482. He invited the Tribunal to conclude that all reasonable efforts had been made to serve the NoH upon Dr Abdel Rahman in accordance with the Rules.

483. Mr Donoghue submitted that the Tribunal could then use its discretion to proceed in Dr Abdel Rahman's absence in accordance with Rule 31 of the Rules. He drew the Tribunal's attention to the cases of *Adeogba & Visvadis v GMC [2016] EWCA Civ 162* and *R v Hayward, Jones & Purvis [2001] QB 862*.

484. Mr Donoghue reminded the Tribunal that Dr Abdel Rahman was no longer engaging with the GMC. He said that it was reasonable, in the circumstances, to infer that Dr Abdel Rahman had made a deliberate decision not to attend today and therefore had voluntarily absented himself.

The Tribunal's Determination

Service

485. The Tribunal had regard to Rule 40 of the Rules. It noted that there had been no contact from Dr Abdel Rahman since 2024. It was satisfied that he was aware of the hearing and service had been effected. It also determined that the NoH letter contained the relevant detail as required by the Rules.

486. Based upon the evidence before it, the Tribunal was satisfied that the NoH had been served upon Dr Abdel Rahman at his registered address in accordance with Rules 40 of the Rules.

Proceeding in Dr Abdel Rahman's Absence

487. In making its determination the Tribunal noted that the decision as to whether or not the hearing should proceed in Dr Abdel Rahman's absence was a matter for its discretion and that such discretion was to be exercised with care and caution. The Tribunal noted Rule 31 for determining applications to proceed in absence which sets out:

> *"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."*

488. The Tribunal took into account the case law referred to by GMC Counsel and the Legally Qualified Chair (LQC).

489. The Tribunal noted that the letters sent to Dr Abdel Rahman informed him of the date, time and venue of the hearing, his right to attend it, and to be legally represented. He was also informed that the hearing could proceed in his absence if he did not attend. The Tribunal concluded, in light of the information before it, that Dr Abdel Rahman had voluntarily absented himself from this hearing.

490. The Tribunal considered whether an adjournment would result in Dr Abdel Rahman attending the hearing. Setting aside that there had been no application for an adjournment, there was no evidence before the Tribunal that an adjournment would result in his attendance.

491. The Tribunal also considered whether any decision to proceed in Dr Abdel Rahman's absence may result in disadvantage or prejudice to him taking account of the fact that it may not necessarily have all of the information which he would wish to present. The Tribunal had received via the GMC a statement from Dr Abdel Rahman that he made for the Trust investigation and his Rule 7 response which it could take into account.

492. The Tribunal noted that the public interest included the need for a fair, economic, expeditious and efficient disposal of the hearing. These matters should be balanced against any prejudice to Dr Abdel Rahman.

493. Having balanced each of the relevant factors against the need to ensure public protection and the public interest the Tribunal determined that it is fair and just to proceed with the hearing in Dr Abdel Rahman's absence.

494. The hearing will therefore proceed in Dr Abdel Rahman's absence.

ANNEX B – 07/07/2026

Application to Amend the Allegation

495. On day two of proceedings Mr Donoghue, counsel on behalf of the GMC made an application, pursuant to Rule 17(6) of the GMC (Fitness to Practise Rules) 2004 as amended ('the Rules'), to amend the Allegation.

496. The proposed amendment was the following:

1. On 25 August 2020 you carried out emergency surgery ('the Procedure') on Patient A and you:
    a. inappropriately performed a gastrojejunostomy in that you made surgical errors, including:
        i. …
        ii. ~~oversewing the staple line that secured the proximal end of the distal small bowel and~~ leaving the proximal end of the distal small bowel ~~it~~ lying in the peritoneal cavity;

Submissions

On behalf of the GMC

497. Mr Donoghue reminded the Tribunal that Rule 17(6) of the Rules permits amendments where they can be made without injustice, after hearing the parties.

498. Mr Donoghue then went on to explain the purpose of the application. He explained that the wording in paragraph 1(a)(ii) had come from Mr C's expert report. However, he said that when Mr C gave his evidence, he could not identify the evidence in the GMC bundle which he relied on to conclude that Dr Abdel Rahman had oversewn the staple line of the proximal end of the distal small bowel. Mr C said that there must have been an end because Mr D had noticed it and later stitched it to the skin as a stoma, and that the true gravamen of the misconduct was leaving the proximal end of the distal small bowel within the peritoneal cavity.

499. Although the Tribunal may ultimately infer that the staple line was oversewn, Mr Donoghue emphasised that the allegation must accurately particularise the misconduct relied upon, and Mr C had been clear that the critical issue was the bowel end being left in the abdomen.

500. Mr Donoghue said that the amendment could be made without injustice to Dr Abdel Rahman. He said that the proposal narrowed what is currently drafted, reduced the wording, and did not add anything to the allegation that was being made. He confirmed that if the paragraph were amended it would still be based on the same evidence which Dr Abdel Rahman had seen and it was not introducing a new area to the case. He also stated that the *error* that was being alleged is that Dr Abdel Rahman left the proximal end of the distal small bowel in the peritoneal cavity and that had not changed.

501. Mr Donoghue said that the Tribunal cannot hear from Dr Abdel Rahman about his views on the proposed amendment but submitted that he had waived his right by voluntarily absenting himself from the proceedings.

502. In conclusion, Mr Donoghue reminded the Tribunal of the seriousness of the case and submitted that the amendment should be made.

The Tribunal's Decision

503. The Tribunal took into account the submissions made by the GMC and considered Rule 17(6) of the Rules, which states:

> *'17.*
> *…*
> *(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.'*

504. The LQC reminded the Tribunal that there are factors for it to consider and balance including:

- The timing of and reason for the application,
- The nature of the amendment sought,
- Whether it should allow the amendment to ensure justice is served without causing undue prejudice to the doctor.

505. The Tribunal accepted the arguments put forward by Mr Donougue. It took the view that the new wording narrowed the issues in the case and did not add a new aspect to it. It was aware that Dr Abdel Rahman had all the evidence before him, and that the clinical misconduct that was being alleged had not changed.

506. The Tribunal noted that the amendment was being made before the end of the GMC case which is an early stage of the hearing.

507. The Tribunal also noted that, had Dr Abdel Rahman attended the hearing he would have been able to address the Tribunal and put forward his defence. However, it concluded he had absented himself and as the amendment introduced no new matters he was not disadvantaged by it.

508. The Tribunal was also mindful of its overarching objective to ensure that the public is protected. It concluded therefore that the amendment could be made without injustice.

509. The Tribunal therefore determined to grant the GMC's application to amend paragraph 1(a)(ii)of the Allegation.

Schedule 1

Persons to notify
His responsible officer (or their nominated deputy)
Responsible officer of his place(s) of work and any prospective place of work (at the time of application)
Responsible officer of all his contracting bodies and any prospective contracting body (prior to entering a contract)
Responsible officer of any organisation where he has, or has applied for, practising privileges and/or admitting rights (at the time of application)
Responsible officer of any locum agency or out-of-hours service he is registered with
If any organisation listed above does not have a responsible officer, he must notify the person with responsibility for overall clinical governance within the organisation. If he is unable to identify this person, he must contact the GMC for advice before working for that organisation.