Neutral Citation Number: [2023] EWHC 3228 (Admin)

Case No: CO/1645/2023
AC-2023-LON-001397

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 18 December 2023

Before :

MRS JUSTICE LANG DBE

- -

Between :

GENERAL MEDICAL COUNCIL	**Appellant**
- and -	
NOUR MOHAMED MAGDY ALY REZK	**Respondent**

- -
- -

Eleanor Grey KC (instructed by **GMC Legal**) for the **Appellant**
Selva Ramasamy KC (instructed by **Medical Protection**) for the **Respondent**

Hearing date: 14 and 29 November 2023

- -

Approved Judgment

This judgment was handed down remotely at 10 am on 18 December 2023 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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Mrs Justice Lang :

1. The Appellant ("the GMC") appeals, pursuant to section 40A of the Medical Act 1983 ("MA 1983"), against a determination of a Tribunal of the Medical Practitioners Tribunal Service ("the MPTS"), on 3 April 2023, that no action should be taken against the Respondent ("Dr Rezk"), in respect of his sexual misconduct and impairment of fitness to practise.

2. In summary, the grounds of appeal are as follows:

   i) The Tribunal failed to attach sufficient weight to the second and third limbs of the over-arching objective in section 1 MA 1983, namely, 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.

   ii) The Tribunal erred in finding that there were "exceptional circumstances" which justified a decision to take no action.

   iii) In the circumstances of this case, the Tribunal ought to have imposed an appropriate sanction, namely, suspension.

Dr Rezk's history

3. Dr Rezk, whose date of birth is 5 June 1991, qualified with a MB Bch (Bachelor of Medicine and Surgery) at Alexandria University in Egypt in October 2014. He then worked a physician in the Directorate of Health Affairs in Alexandria.

4. Dr Rezk moved to the UK in November 2017. He was employed as a junior clinical fellow in Anaesthetics at West Middlesex Hospital between November 2017 and April 2018. Between April and August 2018, Dr Rezk was employed as a Trust grade doctor in Emergency Medicine at the Queen's Medical Centre, Nottingham. Between August 2018 and August 2019, he completed his Core Medical Training in Internal Medicine (CT1) at Derriford Hospital, Plymouth ("Plymouth"), where he met Ms A and Ms B who were, at that time, members of the nursing staff.

5. Dr Rezk began his Speciality Training in Emergency Medicine in August 2019 and was employed at Royal Shrewsbury Hospital as an ST1. Dr Rezk completed the first stage of the Faculty of the Royal College of Emergency Medicine (FRCEM) exams in December 2019. He began as an ST2 in Emergency Medicine in August 2020, at the West Midlands Deanery. He was allocated to the ICU/Anaesthetic department at Walsall Manor Hospital, part of Walsall Healthcare NHS Trust. In March 2021, Dr Rezk completed the next stage of the FRCEM exams and in August 2021, completed his ST2 year.

6. In August 2021, Dr Rezk began his ST3 training in Emergency Medicine at Walsall Manor Hospital and, in September 2021, he completed the third stage of the FRCEM exams. Dr Rezk began work at Birmingham City Hospital, part of Sandwell and West Birmingham NHS Trust, in February 2022 as part of his next rotation. This was due to conclude in August 2022. However due to the fitness to practise proceedings, he was not permitted to progress to ST4 training, although he was allowed to continue

working as an ST3. I was informed at the hearing on 14 November 2023 that he has now commenced his ST4 training.

The allegations

7. On 8 December 2020, a Consultant at Plymouth referred Dr Rezk to the GMC on behalf of Ms A, a junior sister on the Medical Assessment Unit at Plymouth. She had disclosed to him that she had received from Dr Rezk unwanted sexually explicit messages, and pictures of his genitals, between September and December 2020. At that time, Dr Rezk had left Plymouth, and was contacting Ms A via social media.

8. On or about 11 December 2020, Ms B, who was also a junior sister on the Medical Assessment Unit at Plymouth, received messages about sexual activity from Dr Rezk on social media.

9. The Tribunal determined the allegations against Dr Rezk as follows:

> "That being registered under the Medical Act 1983 (as amended):
>
> 1. You were employed as a CT1 trainee by the University Hospitals Plymouth NHS Trust ('the Trust') until 4 August 2019. **Admitted and found proved**
>
> Ms A
>
> 2. Between around September 2020 to December 2020 ('the relevant period'), you communicated with Ms A, your former colleague at the Trust, via Facebook Messenger. The detail of some of these messages is set out in Schedule 1. **Admitted and found proved**
>
> 3. During the relevant period, without solicitation from Ms A, you:
>
> a. sent Ms A a message stating or implying that you had masturbated whilst looking her Facebook profile picture, or words to that effect;
> **Admitted and found proved**
>
> b. stated that you would spank Ms A, or words to that effect; **Admitted and found proved**
>
> c. sent photographs of your genitalia to Ms A on one or more occasion;
> **Admitted and found proved**
>
> d. asked Ms A if she liked certain sexual things, and if her partner liked certain sexual things, or words to that effect;
> **Admitted and found proved**

e. made sexual comments about Ms A's body and appearance; **Admitted and found proved**

f. continued to send messages of a sexual nature to Ms A, despite Ms A requesting on one or more occasion that you stop doing so.
Admitted and found proved

4. When confronted by Ms A regarding your actions at paragraph 3a, you responded stating that you had only done it once, or words to that effect.

Admitted and found proved

5. Your conduct as described at paragraphs 2 to 4 was:

a. inappropriate; **Admitted and found proved**

b. sexually motivated; **Admitted and found proved**

c. sexual harassment of Ms A. **Admitted and found proved**

Ms B

6. On or around 11 December 2020, you communicated with your former colleague at the Trust, Ms B, via Facebook Messenger, details of which are set out in Schedule 2. **Admitted and found proved**

7. Within the messages at Schedule 2, without solicitation from Ms B, you:

a. asked Ms B questions about her past sexual experiences and / or sexuality, or words to that effect; **Admitted and found proved**

b. disclosed to Ms B information about your own past sexual experiences and / or relationships; **Admitted and found proved**

c. asked Ms B about her sexual preferences, or words to that effect; **Admitted and found proved**

d. continued to ask Ms B about her sexual preferences, despite Ms B stating that it would be inappropriate for her to respond, or words to that effect. **Admitted and found proved**

8. Your conduct as described at paragraphs 6 and 7 was:

a. inappropriate; **Admitted and found proved**

b. sexually motivated; **Admitted and found proved**

c. sexual harassment of Ms B. **Admitted and found proved**

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

Misconduct

10. The Tribunal found that the matters proved, which they characterised as sexual harassment, amounted to serious misconduct, for the following reasons:

> "59. Subject to its determination on the matters which Dr Rezk advanced to explain his behaviour, the Tribunal considered that the facts which were found proved on Dr Rezk's admission in relation to Ms A and Ms B and which were inappropriate, sexually motivated and amounted to sexual harassment were sufficiently serious to amount to misconduct. Dr Rezk's Facebook Messenger messages to Ms A included but were not limited to:
>
> • sending her a message stating or implying that he had masturbated whilst looking at her Facebook profile picture, or words to that effect;
>
> • sending photographs of his genitalia on three immediately successive occasions;
>
> • persisting in his sending messages of a sexual nature despite Ms A requesting that he cease to do so.
>
> 60. In Dr Rezk's Facebook Messenger messages to Ms B:
>
> • he asked her questions about her own past sexual experiences and preferences and / or her sexuality,
>
> • disclosed information concerning his own past sexual experiences and relationships, and
>
> • continued to ask her about her sexual preferences notwithstanding that she stated that it would be inappropriate for her to respond.
>
> 61. Dr Rezk had only known Ms A and Ms B whilst he was doing his core training between August 2018 and August 2019. They were both nurses in the University Hospitals Plymouth NHS Trust at the time of his core training. The messages were sent to them in late 2020.

62. The Tribunal found that, by his behaviour, Dr Rezk breached the following paragraphs of GMP, 2013 edition:

Paragraph 36: *"You must treat colleagues fairly and with respect"*

Paragraph 65: *"You must make sure that your conduct justifies … the public's trust in the profession."*

63. The explanation that Dr Rezk advances for his behaviour was that, although he was 29 years old, he was immature, and that working in the ICU / Anaesthetic department at Walsall Manor Hospital when the covid epidemic was rife was extremely pressurised and stressful for him, both at work and where he lived. At the time he was living alone; he felt isolated; he did not see people socially; his parents were in a different country; he spent a significant period of his days "on-line".

64. The Facebook Messenger texts which the Tribunal has seen, but which do not amount to the complete sequence of communications between Dr Rezk and Ms A and Ms B demonstrate that he was persistently pushing the boundaries of what would be appropriate between erstwhile colleagues and that he was interested in discussing sexual matters, notwithstanding that these matters were not encouraged or initiated by Ms A or Ms B. The extremity of the approach of Dr Rezk is demonstrated by the particular instances cited above. Both Ms A and Ms B blocked Dr Rezk from their Facebook Messenger accounts. There is some suggestion that when Ms A blocked Dr Rezk from his account, he concentrated on Ms B.

65. The Tribunal accepted that in sending these messages and in the case of Ms A photographs of himself, Dr Rezk demonstrated a significant degree of immaturity. However, the Tribunal was satisfied, as Dr Rezk admitted, that the messaging was sexually motivated. The Tribunal finds that he was concerned to satisfy his own desires and that he was not interested in the fact that his messages were unwelcome to either Ms A or Ms B. Effectively he rode roughshod over their dismay in receiving the messages. He was not able to explain to the Tribunal how he intended that the stress which he was enduring would be alleviated by his conduct towards Ms A and / or Ms B beyond saying it was to do with him being human. Nor did he call any evidence from Dr Sura, a treating Psychologist, to explain his behaviour.

66. The Tribunal has reached the conclusion that the explanations which Dr Rezk advanced do not mitigate his behaviour which, objectively, amounted to harassment of Ms A and Ms B. To be fair, Dr Rezk admitted misconduct before the

> Tribunal. The Tribunal therefore concluded that the matters found proved amounted to misconduct which was serious."

Impairment

11. The Tribunal found that Dr Rezk's fitness to practise was impaired on public interest grounds, and that such a finding was necessary to uphold proper professional standards and conduct, and to maintain public confidence in the profession.

12. The Tribunal's reasons were as follows:

> "67. The Tribunal therefore turned to consider whether Dr Rezk's fitness to practise is impaired by that misconduct.
>
> 68. The Tribunal noted that Dr Rezk has undertaken a number of CPD courses as set out above.
>
> 69. It noted that Dr Rezk did not embark on these courses immediately following his being blocked by Ms A and 'unfriended' by Ms B from their Facebook Messenger accounts. The first, *"Professional Boundaries in Practice"* was undertaken in June 2021 when he became aware of the detail of the initial accounts of Ms A and Ms B through the GMC. No further courses were taken until March 2022, that is after he had received a Rule 7 letter from the GMC in February 2022. In addition, Dr Rezk attended sixteen Psychological Therapy appointments with Dr Sura from 13 April 2022 to 28 February 2023, the majority of which were towards the end of 2022 and the first part of 2023. He explained that the trigger for his seeking psychological assistance was his being reported to the GMC in respect of another matter in the early part of 2022, although this was not a matter which gave rise to any concerns. He stated that he finally realised that this case was to do with himself, who he was and that he needed to address his shortcomings if he was to continue to be a doctor in the UK.
>
> 70. Dr Rezk gave evidence to the Tribunal. As set out elsewhere, he expressed remorse and apologised for his behaviour towards Ms A and Ms B, to the GMC and to this Tribunal. Although he stated in his witness statement in February 2023 that he honestly believed that his conversation with Ms A was mutual, the Tribunal accepted his oral evidence that he no longer believed this to have been the case. He asserted that he had gained insight into his behaviour, that he needed to learn why and where he had gone so wrong and had in fact achieved this. He said that he had followed Dr Sura's recommendations that he write but not send letters to Ms A and Ms B regarding his behaviour. These were in the bundle and they do express appropriate contrition. He followed, in part, Dr Sura's recommendation that he disclose his behaviour to his

parents, and his fiancée but only to the extent that he was before the MPTS; he did not disclose the detail or let them have sight of the allegations which he was facing. He explained the importance of his career in medicine to him. He produced a number of references and testimonials which attest to the fact that he is doing well in his career, and that he is well liked by his colleagues. Dr Taylor Davis, a consultant in emergency medicine gave evidence on his behalf and explained how he was a valued member of the team in her department.

71. The Tribunal accepted that following his attendance on the courses and the psychological therapy sessions, Dr Rezk has gained considerable insight into his behaviour to the extent that it is satisfied that it is most unlikely that he will ever behave in a similar way again. Although his attendances may have been occasioned by his forthcoming appearance before the MPTS, nevertheless he has addressed his misconduct and his capacity to commit misconduct of this nature. His commitment to his career and his shame of being brought before his regulator may also have been factors in motivating him.

72. Whilst the Tribunal was satisfied that Dr Rezk's fitness to practise was impaired at the time of the events in question and for a period thereafter, it does not find that his fitness to practise is impaired at the present time on purely public protection grounds.

73. The Tribunal now turns to whether a finding of impairment is warranted in the wider public interest. Such a finding is appropriate if there is a need to uphold proper professional standards and conduct and maintain public confidence in the profession. Such a need would arise if, by his misconduct, Dr Rezk has brought the profession into disrepute or breached a fundamental tenet of the profession. The Tribunal has already found that Dr Rezk breached two paragraphs of GMP.

74. It was submitted by Ms O'Halloran that this case was serious but at the bottom end of the spectrum of seriousness of sexually motivated misconduct as set out in *General Medical Council v Ahmed [2022] EWHC 403 (Admin)*. She submitted that there were a number of factors about the case which the Tribunal should take into account as follows: No patient involvement; No professional relationship at the time; No senior / junior abuse of power; No touching and no physical or sexual contact; No malicious intention; Immature and inappropriate communication of romantic/sexual interest; Doctor of very junior standing; Described by Ms A as much younger than her; No police involvement; Isolated during the pandemic and increased online activity.

75. The Tribunal had some reservations about the proposition that there was no senior / junior aspect of this case given that Dr Rezk chose members of the nursing profession to whom to send his communications, but it does not consider that there was an abuse of power, and broadly it accepted Ms O'Halloran's listed factors about the case.

76. However, regardless of where this case sits on the spectrum of seriousness, Dr Rezk failed to treat his colleagues with respect. In the view of the Tribunal, the fact that they were no longer working in the same hospital environment is not particularly significant. He had first met them as colleagues when he was working at Derriford Hospital, and it was on account of his having known them in that capacity that he saw them as persons with whom he could correspond; and he allowed his sexual motivation to colour the way he corresponded with them. They remained his colleagues in the NHS. Dr Rezk not only failed to treat his colleagues with respect, he sexually harassed them.

77. The Tribunal considered that treating colleagues with respect is a fundamental tenet of the profession. It is enshrined in GMP, and clearly is of enormous importance in enabling the medical profession to care for and protect patients. Both nurses were upset by his text messages and, in Ms A's case, his sending her photographs of his anatomy. The Tribunal concluded that Dr Rezk breached that fundamental tenet of the profession.

78. The decision as to whether the Tribunal should mark that with a finding that Dr Rezk's fitness to practise is impaired is not going to be influenced by whether he has addressed his misconduct after the events in question. It will be influenced by whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment is not made.

79. It is right to note that the MPTS does have the jurisdiction to issue a warning, and that could reflect the Tribunal's attitude to behaviour of the kind found proved in this case. However, the power to warn is only available to the Tribunal if it has reached the conclusion that Dr Rezk's fitness to practise is not impaired. The Tribunal considers that the public would be dismayed if it did not make a finding of impairment where behaviour such as this has been found proved. It has reached the conclusion that Dr Rezk's fitness to practise is impaired on wider public interest grounds because such a finding is necessary to uphold proper professional standards and conduct and to maintain public confidence in the profession.

> 80. The Tribunal therefore finds that Dr Rezk's fitness to practise is currently impaired."

Sanctions

13. At paragraph 102 of the Determination ("D/102"), the Tribunal stated that it took into account its earlier findings during its deliberations on sanction. At D/103-105 and D/110-114, the Tribunal had regard to the guidance given in the Sanctions Guidance ("SG")

14. At D/106-108, the Tribunal set out the mitigating and aggravating factors.

15. At D/110, the Tribunal set out SG/20 which referred to the principle that the Tribunal should consider the sanctions available, starting with the least restrictive. It should also have regard to the principle of proportionality.

16. At D/111-112, the Tribunal decided that neither conditions nor suspension were appropriate or proportionate sanctions, for the following reasons:

> "111. In view of its finding that Dr Rezk is most unlikely to repeat his behaviour, the Tribunal considers that the interests of the public are limited to the promotion and maintenance of confidence in the profession and of proper standards of conduct for members of the profession. A finding of current impairment represents a significant judgment on a doctor who has, as in this case, breached a fundamental tenet of the profession and thereby brought the profession into disrepute. However, there is another facet of the public interest which the Tribunal should not ignore. That is that it should enable a doctor to continue with his training and his career if it would be in the public interest and consistent with the overarching objective of protecting the public for it to do so. When the Tribunal considers the sanctions which are available to it, it does note that the least restrictive sanctions namely the imposition of conditions or alternatively a suspension order do not naturally commend themselves. The Sanctions Guidance offers the following as guidance in respect of conditions:
>
> > In many cases, the purpose of conditions is to help the doctor to deal with their health issues and/or remedy any deficiencies in their practice or knowledge of English, while protecting the public. In such circumstances, conditions might include requirements to work under supervision.
>
> 112. In the light of its finding that Dr Rezk has addressed his shortcomings, the Tribunal did not consider that conditions represented a sanction which would be proportionate. Dr Rezk has nothing more to achieve by way of remediation. So far as a sanction of suspension is concerned, the Tribunal considered

> that this would not be appropriate. Dr Rezk has demonstrated by the MSF and by the testimonials, and in particular by the oral evidence of Dr Taylor Davis, one of his referees and a Consultant in Emergency Medicine at Birmingham City Hospital, that he has the capacity to be a good, if not excellent, doctor in emergency medicine in this country. Moreover, Dr Rezk adduced evidence at the sanction stage from the *"Reference Guide for Postgraduate Foundation and Specialty Training in the UK"*, the Gold Guide, 9th Edition published 3 August 2022, in particular paragraph 3.99 which satisfied the Tribunal that, if he was suspended, the likelihood would be that he will lose his Training contract. In fact that evidence also supported the proposition that his training contract would be in jeopardy if any sanction was imposed. Currently he has been allowed to retain his ST3 rotation at Birmingham City Hospital from August 2022; in consequence he remains on the training programme."

17. The Tribunal then concluded that there were exceptional circumstances in this case which justified taking no action. At D/113, it quoted the guidance at SG/68-70, and said:

> "114. The Tribunal's view as to the value of imposing a sanction is set out above. However, it recognised that it could only justify taking no action if there were exceptional circumstances. It has reached the decision that there are exceptional circumstances as follows:
>
> • Save for the period between September and December 2020, Dr Rezk has been a diligent, conscientious and professional doctor on a training programme which he was completing in an exemplary fashion;
>
> • The ST2 rotation in ICU at Walsall Manor Hospital upon which he was engaged was exceptionally stressful and demanding. It was at the height of the covid 19 pandemic. He told the Tribunal about the stress which he endured; how covid 19 patients attended the hospital apparently well but who deteriorated to the point of dying in the hospital's care; how he and his colleagues were often helpless at the time. All the while he was in the ICU department where the pressure would have been at its highest. That in itself would have caused exceptional strain.
>
> • He was obliged to experience that pressure and endure that strain in an isolated environment. He lived alone. He has only been in the UK since November 2017. Since that time, he had moved around the country on different rotations: West Middlesex November 2017 to April 2018; Nottingham April 2018 to August 2018; Plymouth August 2018 to August 2019; Shrewsbury August 2019 to August 2020. He had only started

the rotation in Walsall Manor Hospital in August 2020. A measure of his loneliness was that he commenced communicating with Ms A in about September 2019 some 12 months after he had left Derriford Hospital in Plymouth.

• The covid 19 pandemic obliged him to communicate when at home entirely on the internet. He was away from his family and his network of friends. It is noteworthy that the inappropriate messages to Ms A commenced in September 2020, one month after the start of his rotation to Walsall Manor Hospital.

• The Tribunal accepts that given the regular rotations, and the impact of the pandemic, he had not been living in the UK sufficiently long enough to enable him to conduct himself in a difficult situation appropriately.

115. The reasons why these circumstances are exceptional are that Dr Rezk suddenly found himself in a situation whereby he did not have the inner resource and the outward comfort and assistance of family and friendships (either singular or group) to cope with the strain and pressure of caring for quantities of patients who were becoming very unwell in the pandemic, and for dealing with the personal emotional toll this situation had on him.

116. The Tribunal considers that taking no action in this situation is justified for the following reasons:

• It does not consider that Dr Rezk would have behaved as has been found proved had these exceptional circumstances not arisen;

• He has never behaved in such a way before or after. In contrast, everything he has done in his training has been professionally approached with a view to his achieving his goal of being an Emergency Medicine Consultant. This behaviour was out of character.

• The experience of being arraigned before his regulator and the MPT and the consequent shame he has experienced for his behaviour will have represented a huge learning experience for Dr Rezk.

• The finding of impairment, made solely on public interest grounds, represents a mark on his registration which will inform and satisfy the public that the profession does not countenance this sort of behaviour in any circumstances.

• There is no point in imposing conditions on Dr Rezk's registration as he has already addressed his shortcomings. In

addition, a sanction of conditions could jeopardise his training number.

• There would be a public interest in allowing Dr Rezk to maintain his training number and continue his career without restriction as the public would benefit from a competent doctor.

• The sanction of a suspension order would send out an even stronger signal to him and to the profession that Dr Rezk's behaviour is not acceptable but the Tribunal does not consider that that would be fair and appropriate given the exceptional circumstances of the case, and it considers that that would be inappropriate as it would mean that Dr Rezk would almost certainly lose his training number. The Tribunal is satisfied that Dr Rezk should be permitted to retain his training number and have the chance of realising the faith and trust which his colleagues in the Emergency Department of Birmingham City Hospital, including the Consultant, have in him.

117. In the light of the foregoing, the Tribunal has determined to take no action and therefore imposes no sanction in this case."

Legal framework

MA 1983

18. The over-arching objectives of the GMC are set out in section 1 MA 1983:

> "(1A) The over-arching objective of the General Council in exercising their functions is the protection of the public.
>
> (1B) The pursuit by the General Council of their over-arching objective involves the pursuit of the following objectives—
>
> (a) to protect, promote and maintain the health, safety and well-being of the public,
>
> (b) to promote and maintain public confidence in the medical profession, and
>
> (c) to promote and maintain proper professional standards and conduct for members of that profession."

19. Under section 35D(2) MA 1983, where a medical practitioners tribunal ("MPT") finds that a practitioner's fitness to practise is impaired, "they may, if they think fit":

i) direct that the person's name be erased from the register;

ii) direct that the person's registration be suspended, during a period not exceeding 12 months;

iii) direct that the person's registration be subject to conditions, during a period not exceeding 3 years.

20. The lesser sanction of a warning is only available, under section 35D(3) MA 1983, where a MPT finds that the person's fitness to practise is not impaired.

21. Under section 40 MA 1983, a practitioner has the right to appeal to the High Court against orders of erasure, suspension and conditional registration made against the practitioner.

22. Section 40A MA 1983 confers on the GMC a right of appeal to the High Court as follows:

> "**40A.— Appeals by General Council**
>
> (1) This section applies to any of the following decisions by a Medical Practitioners Tribunal—
>
> (a) a decision under section 35D giving—
>
> (i) a direction for suspension, including a direction extending a period of suspension;
>
> (ii) a direction for conditional registration, including a direction extending a period of conditional registration;
>
> (iii) a direction varying any of the conditions imposed by a direction for conditional registration;
>
> ……
>
> (d) a decision not to give a direction under section 35D;
>
> …..
>
> (2) A decision to which this section applies is referred to below as a *"relevant decision"*.
>
> (3) The General Council may appeal against a relevant decision to the relevant court if they consider that the decision is not sufficient (whether as to a finding or a penalty or both) for the protection of the public.
>
> (4) Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient—
>
> (a) to protect the health, safety and well-being of the public;
>
> (b) to maintain public confidence in the medical profession; and

> (c) to maintain proper professional standards and conduct for members of that profession."

Appellate jurisdiction

23. The appeal is governed by CPR part 52 and PD 52D. Under CPR 52.21(3), the question for the court is whether the decision of the Tribunal is "wrong" or "unjust because of a serious procedural or other irregularity in the proceedings in the lower court".

24. The leading authority on appeals under section 40A MA 1983 is *Bawa-Garba v General Medical Council* [2018] EWCA Civ 1879, in which the Lord Chief Justice, giving the judgment of the court, said:

> "60. The GMC's appeal from the Tribunal to the Divisional Court pursuant to section 40A of MA 1983 was by way of review and not re-hearing. In that respect, it differs from an appeal pursuant to section 40. Sub-paragraphs 19.1(1)(e) and (2) of Practice Direction 52D expressly state that appeals under section 40 are to be conducted by way of rehearing. Appeals pursuant to section 40A are governed by CPR 52.21(1), which provides that, subject to the exceptions mentioned there, appeals are limited to a review of the decision under appeal. That technical difference may not be significant. Whether the appeal from the MPT is pursuant to section 40 or section 40A, the task of the High Court is to determine whether the decision of the MPT is "wrong". In either case, the appeal court should, as a matter of practice, accord to the MPT the same respect: *Meadow v General Medical Council* [2006] EWCA Civ 1390, [2007] QB 462 at [126]-[128].
>
> 61. The decision of the Tribunal that suspension rather than erasure was an appropriate sanction for the failings of Dr Bawa-Garba, which led to her conviction for gross negligence manslaughter, was an evaluative decision based on many factors, a type of decision sometimes referred to as "a multi-factorial decision". This type of decision, a mixture of fact and law, has been described as "a kind of jury question" about which reasonable people may reasonably disagree: *Biogen Inc v Medeva Plc* [1997] RPC 1 at 45*; Pharmacia Corp v Merck & Co Inc* [2001] EWCA Civ 1610, [2002] RPC 41 at [153]; *Todd v Adams (t/a Trelawney Fishing Co) (The Maragetha Maria)* [2002] EWCA Civ 509, [2002] 2 Lloyd's Rep 293 at [129]; *Datec Electronics Holdings Ltd v United Parcels Service Ltd* [2007] UKHL 23, [2007] 1 WLR 1325 at [46]. It has been repeatedly stated in cases at the highest level that there is limited scope for an appellate court to overturn such a decision….
>
> ……

> 67. That general caution applies with particular force in the case of a specialist adjudicative body, such as the tribunal in the present case, which (depending on the matter in issue) usually has greater experience in the field in which it operates than the courts: see *Smech* at [30]; *Khan v General Pharmaceutical Council* [2016] UKSC 64, [2017] 1 WLR 169 at [36]; *Meadow* at [197]; and *Raschid v General Medical Council* [2007] EWCA Civ 46, [2007] 1 WLR 1460 at [18]-[20]. An appeal court should only interfere with such an evaluative decision if (1) there was an error of principle in carrying out the evaluation or (2) for any other reason, the evaluation was wrong, that is to say it was an evaluative decision which fell outside the bounds of what the adjudicative body could properly and reasonably decide: *Biogen* at [45]; *Todd* at [129]; *Designers Guild Ltd v Russell Williams (Textiles) Ltd (trading as Washington DC)* [2001] FSR 11 (HL) at [29]; *Buchanan v Alba Diagnostics Ltd* [2004] UKHL 5, [2004] RPC 34 at [31]. As the authorities show, the addition of 'plainly' or 'clearly' to the word 'wrong' adds nothing in this context."

25. In *General Medical Council v Jagjivan & Another* [2017] EWHC 1247 (Admin); [2017] 1 WLR 4438, which pre-dated the judgment in *Bawa-Garba*, Sharp LJ summarised the principles to be applied to appeals under section 40A MA 1983, at [40]:

> "In summary:
>
> (i) Proceedings under section 40A of the 1983 Act are appeals and are governed by CPR part 52. A court will allow an appeal under CPR part 52.21(3) if it is 'wrong' or 'unjust because of a serious procedural or other irregularity in the proceedings in the lower court'.
>
> (ii) It is not appropriate to add any qualification to the test in CPR part 52 that decisions are 'clearly wrong': see *Fatnani* at paragraph 21 and *Meadow* at paragraphs 125 to 128.
>
> (iii) The court will correct material errors of fact and of law: see *Fatnani* at paragraph 20. Any appeal court must, however, be extremely cautious about upsetting a conclusion of primary fact, particularly where the findings depend upon the assessment of the credibility of the witnesses who the tribunal, unlike the appellate court, has had the advantage of seeing and hearing (see *Assicurazioni Generali SpA v Arab Insurance Group (Practice Note)* [2002] EWCA Civ 1642; [2003] 1 WLR 577, at paragraphs 15 to 17, cited with approval in *Datec Electronics Holdings Ltd v United Parcels Service Ltd* [2007] UKHL 23; [2007] 1 WLR 1325 at paragraph 46, and *Southall* at paragraph 47).

> (iv) When the question is what inferences are to be drawn from specific facts, an appellate court is under less of a disadvantage. The court may draw any inferences of fact which it considers are justified on the evidence: see CPR part 52.11(4).
>
> (v) In regulatory proceedings, the appellate court will not have the professional expertise of the tribunal of fact. As a consequence, the appellate court will approach tribunal determinations about whether conduct is serious misconduct or impairs a person's fitness to practise and what is necessary to maintain public confidence and proper standards in the profession and sanctions with diffidence: see *Fatnani* at paragraph 16 and *Khan v General Pharmaceutical Council* [2016] UKSC 64; [2017] 1 WLR 169, at paragraph 36.
>
> (vi) However, there may be matters, such as dishonesty or sexual misconduct, where the court 'is likely to feel that it can assess what is needed to protect the public or maintain the reputation of the profession more easily for itself and thus attach less weight to the expertise of the tribunal ...': see *Council for the Regulation of Healthcare Professionals v GMC and Southall* [2005] EWHC 579 (Admin); [2005] Lloyd's Rep Med 365 at paragraph 11, and *Khan* at paragraph 36(c). As Lord Millett observed in *Ghosh v GMC* [2001] UKPC 29; [2001] 1 WLR 1915 and 1923G, the appellate court 'will afford an appropriate measure of respect of the judgment in the committee ... but the [appellate court] will not defer to the committee's judgment more than is warranted by the circumstances'.
>
> (vii) Matters of mitigation are likely to be of considerably less significance in regulatory proceedings than to a court imposing retributive justice because the overarching concern of the professional regulator is the protection of the public.
>
> (viii) A failure to provide adequate reasons may constitute a serious procedural irregularity which renders the tribunal's decision unjust (see *Southall* at paragraphs 55 to 56)."

26. In *Sastry v General Medical Council* [2021] EWCA Civ 623, Nicola Davies LJ identified the distinction between the approach of the court in re-hearings in section 40 appeals and reviews in section 40A appeals, as follows:

> "108. We endorse the approach of the court in *Bawa-Garba*, as appropriate to the review jurisdiction applicable in section 40A appeals. We regard the approach of the court in section 40 appeals, as identified in *Ghosh* and approved in *Khan*, as appropriate in section 40 appeals which are by way of a rehearing."

Nicola Davies LJ later added, at [113]:

> "113. …. We agree that in matters such as dishonesty or sexual misconduct, the court is well placed to assess what is needed to protect the public or maintain the reputation of the profession and is less dependent upon the expertise of the Tribunal. It follows that we find that the approach of the judge to the sanction imposed upon Dr Okpara was wrong in that he did not assess whether the sanction was necessary or appropriate in the public interest or was excessive or disproportionate."

27. Ms Grey KC relied in particular upon the well-established principle that the reputation of the profession is more important that the fortunes of an individual practitioner, which was authoritatively expressed in *Bolton v Law Society* [1994] 1 WLR 512 by Sir Thomas Bingham M.R., at 518A-519E.

28. The *Bolton* principles were applied in *Hanna v GMC* [2021] EWHC 3716 (Admin) in which the High Court upheld an MPT's decision to suspend an Egyptian national doctor for 4 months for sexual misconduct as appropriate and necessary, despite the fact that it resulted in the termination of his contract of employment and thus the curtailment of his leave to remain in the UK.

29. The way in which a tribunal should approach a case in which the misconduct may undermine public confidence in the profession was considered by Sales J. in *Yeong v General Medical Council* [2009] EWHC 1923 (Admin), at [50]-[51].

30. *Yeong* and *Bolton* were applied by the Court of Appeal in *GMC v Chandra* [2018] EWCA Civ 1898, per King LJ at [90], in an appeal by the GMC under section 40A MA 1983 against a MPT decision to restore a doctor to the medical register after erasure for sexual misconduct.

31. In *GMC v Mehta* [2018] CSIH 69, the Inner House of the Court of Session dismissed an appeal by the GMC under section 40A MA 1983 against a decision by an MPT to impose no sanction upon a doctor whose fitness to practise was impaired by reason of inappropriate and sexually motivated conduct towards a junior doctor. The decision turned on its own unusual facts, and the Court did not set out any wider principles or guidance.

32. The Court was satisfied that the MPT had recognised the overarching objective of public protection, and considered whether the maintenance of professional standards and public confidence in the profession would be compromised by the decision (at [26]). The Court rejected the submission that the MPT did not have due regard to the SG (at [30]). It was clear that the MPT did take the relevant provisions into account, even though they were not expressly referred to. It was not necessary to refer to each paragraph in the SG, as "[t]o do so could result in the process becoming more of a "box ticking" exercise rather than an evaluation of the complaint within its own factual matrix" (at [28]). At [33], the Court addressed the issue of exceptional circumstances, as follows:

> "[33] The appellant's third argument proceeds on the basis that remediation and insight cannot constitute "exceptional" reasons in terms of paragraph 69. Such an interpretation is incorrect. The paragraph's terms are clear. While remediation and insight

> are "unlikely on their own to justify a tribunal taking no action", there is nothing in principle preventing them from being the determining factors. The Tribunal had already decided that the personal remediation was not sufficient, even against a finding that there was no likelihood of repetition, to prevent a finding of impairment. On the question of sanctions, insight and remediation were influencing factors, but they were by no means the only ones. The factors which the Tribunal considered in respect of exceptional circumstances went far beyond the sort of remediation which might be relevant to determining whether past conduct justified a finding of current impairment. The respondent had participated in public presentations on the subject, educating the profession in which he works to prevent others from crossing boundaries, and educating junior staff to speak up. Such activities, and the impact they might have on public confidence in the profession, were important and distinct considerations for the tribunal…."

Sanctions Guidance

33. The SG is non-statutory guidance which is approved by the Council of the GMC, and developed by a steering group of Medical Practitioners, Tribunal Service and GMC staff, for use by MPTs.

34. Under the heading "**Why do we impose sanctions?**", the SG states:

> "14 The main reason for imposing sanctions is to protect the public. This is the statutory overarching objective, which includes to:
>
> a protect and promote the health, safety and wellbeing of the public
>
> b promote and maintain public confidence in the medical profession
>
> c promote and maintain proper professional standards and conduct for the members of the profession.
>
> 15 Each reference to protecting the public in this guidance should be read as including the three limbs of the overarching objective set out in paragraph 14.
>
> 16 Sanctions are not imposed to punish or discipline doctors, but they may have a punitive effect.
>
> *Maintaining public confidence in the profession*
>
> 17 Patients must be able to trust doctors with their lives and health, so doctors must make sure that their conduct justifies their patients' trust in them and the public's trust in the

> profession (see paragraph 65 of Good medical practice). Although the tribunal should make sure the sanction it imposes is appropriate and proportionate, the reputation of the profession as a whole is more important than the interests of any individual doctor.
>
> *Promoting and maintaining proper professional standards and conduct*
>
> 18 Failure to follow Good medical practice does not automatically mean action will be taken. The guidance sets out the principles of good practice, not thresholds at which it is considered a doctor is unsafe to work.
>
> 19 Good medical practice is the benchmark that doctors are expected to meet subject to any mitigating or aggravating factors. Action is taken where a serious or persistent breach of the guidance has put patient safety at risk or undermined public confidence in doctors."

35. The SG gives guidance on taking a proportionate approach to imposing sanctions: see Judgment [120] below.

36. **Mitigating factors**. The SG advises that the "tribunal needs to consider and balance any mitigating factors presented by the doctor against the central aim of sanctions (see paragraphs 14-16)" (SG/24). At SG/25, it sets out "examples" of mitigating factors.

37. The SG also considers the potential relevance (as mitigating factors) of the extent of a doctor's professional experience and/or whether he or she has come from another country where different professional standards and social/cultural norms may apply (SG/27–30).

38. **Aggravating factors**. The SG advises that the "tribunal needs to consider any aggravating factors presented to it against the central aim of sanctions (see paragraphs 14-16)" (SG/50). Aggravating factors listed are lack of insight (SG/51-53) and previous finding of impairment (SG/54). Under the heading "*Circumstances surrounding the event*", SG/55 states:

> "55 Aggravating factors that are likely to lead the tribunal to consider taking more serious action include:
>
> a a failure to raise concerns (see paragraphs 133–135)
>
> b a failure to work collaboratively with colleagues (see paragraphs 136–138)
>
> c discrimination against patients, colleagues and other people (see paragraphs 139–141)
>
> d abuse of professional position (see paragraphs 142–150), particularly where this involves:

> i vulnerable patients (see paragraphs 145–146)
>
> ii predatory behaviour (see paragraphs 147–148)
>
> e sexual misconduct (see paragraphs 149–150)
>
> f sexual offences and/or child sex abuse materials (see paragraphs 151–159)
>
> g drug or alcohol use disorder linked to misconduct or criminal offences (see paragraphs 160–162)."

39. In this case, the GMC referred to the factors listed at (b), (c), (d) and (e).

40. Further aggravating factors are considered under the heading "*Conduct in a doctor's personal life*". SG/56 states:

> "Tribunals are also likely to take more serious action where certain conduct arises in a doctor's personal life, such as (this list is not exhaustive):
>
> ……
>
> d misconduct involving violence or offences of a sexual nature (see paragraphs 149–150)
>
> ….."

41. In this case, the GMC referred to the factor listed at sub-paragraph (d).

42. Under the heading "**Cases that indicate more serious action is likely to be required**", the SG considers these factors in further detail. I set out below those passages of particular relevance to this case.

43. Under the heading "*Failure to work collaboratively with colleagues*", SG/136-138 provides:

> "136 Doctors are expected to work collaboratively with colleagues to maintain or improve patient care. These duties are set out in paragraphs 35–37 of Good medical practice.
>
> 137 Colleagues include anyone a doctor works with, whether or not they are also doctors.
>
> 138 More serious outcomes are likely to be appropriate if there are serious findings that involve:
>
> …..b sexual harassment
>
> ….."

44. Under the heading *Sexual misconduct*, the introductory paragraphs state:

> "149 This encompasses a wide range of conduct from criminal convictions for sexual assault and sexual abuse of children (including child sex abuse materials) to sexual misconduct with patients, colleagues, patients' relatives or others…..
>
> 150 Sexual misconduct seriously undermines public trust in the profession….."

45. Sanctions are considered under the heading "**Deciding what sanction to impose when a doctor's fitness to practice is impaired**". Guidance on the overall approach is set out at SG/66-67:

> "66 Where a tribunal finds a doctor's fitness to practise is impaired, it can:
>
> a take no action (see paragraphs 68–70)
>
> b agree to accept undertakings …
>
> c impose conditions on the doctor's registration for up to three years (see paragraphs 79–90)
>
> d suspend the doctor's registration for up to 12 months (see paragraphs 91–106)
>
> e erase the doctor's name from the medical register, except in cases relating solely to a doctor's health and/or knowledge of English language (see paragraphs 107–111).
>
> 67 The tribunal's written decision is known as the determination. It must give clear and cogent reasons (including mitigating and aggravating factors that influenced its decision) for imposing a particular sanction. It must show that it started by considering the least restrictive option, working upwards to the most appropriate and proportionate sanction. This is particularly important where the sanction is lower, or higher, than that suggested by this guidance and/or where it differs from those submitted by the parties. In addition, the determination should include a separate explanation as to why the sanction should last for a particular period."

46. The SG then gives guidance on each of these sanctions, beginning with the least restrictive option of "take no action" SG/68-70 state as follows:

> "**Take no action**
>
> 68 Where a doctor's fitness to practise is impaired, it will usually be necessary to take action to protect the public (see paragraphs 14–16). But there may be exceptional circumstances to justify a tribunal taking no action.

> 69 To find that a doctor's fitness to practise is impaired, the tribunal will have taken account of the doctor's level of insight and any remediation, and therefore these mitigating factors are unlikely on their own to justify a tribunal taking no action.
>
> 70. Exceptional circumstances are unusual, special or uncommon, so such cases are likely to be very rare. The tribunal's determination must fully and clearly explain:
>
> a what the exceptional circumstances are
>
> b why the circumstances are exceptional
>
> c how the exceptional circumstances justify taking no further action."

47. Turning now to the case law on the SG, in *Bawa-Garba v GMC*, Lord Burnett described it in the following terms, at [83]:

> "The Sanctions Guidance contains very useful guidance to help provide consistency in approach and outcome in MPTs and should always be consulted by them but, at the end of the day, it is no more than that, non-statutory guidance, the relevance and application of which will always depend on the precise circumstances of the particular case…"

48. In *Professional Standards Authority v The Health and Care Professions Council and Doree* [2017] EWCA Civ 319, the Court of Appeal gave guidance on the approach to be taken to the 'Indicative Sanctions Guidance' published by the Council, at [26] – [29]. Lindblom LJ concluded:

> "29. I see no basis in the relevant jurisprudence for the contention that it was incumbent on the Panel to "adhere" to the guidance in the Indicative Sanctions Policy if that concept is intended to mean anything more than having proper regard to the guidance and applying it as its own terms suggest, unless the Panel had sound reasons for departing from it – in which case they had to state those reasons clearly in their decision."

49. In *GMC v Khetyar* [2018] EWHC 813 (Admin), at [22], Andrew Baker J. characterised the SG's guidance on the principle of proportionality as an "authoritative steer". Whilst the MPTs were entitled to depart from that steer, "[d]oing so requires careful and substantial case-specific justification".

Ground 1

Ms Grey KC's submissions

50. Under Ground 1, Ms Grey KC submitted that the Tribunal gave insufficient weight to the maintenance of public confidence and professional standards when it decided to

take no action, and not to impose a sanction. The Tribunal's conclusion was wrongly arrived at, being reached:

i) following an inadequate consideration of the seriousness of the misconduct (**Limb 1**);

ii) following inadequate consideration of the public interest in maintaining public confidence in the profession and maintaining proper professional standards (**Limb 2**); and

iii) prematurely, as it was arrived at before any or proper consideration of whether there were exceptional circumstances justifying taking no further action (**Limb 3**).

51. **Limb 1**. Ms Grey KC submitted that the Tribunal's consideration of the mitigating and aggravating factors was unbalanced. There was little or no consideration of, or reflection by, the Tribunal about the seriousness of the sexual misconduct and the importance of maintaining appropriate boundaries with colleagues in the NHS and to ensure that they felt respected and safe in the workplace. Considerable emphasis and weight was given to the mitigating factors and the aggravating factors received insufficient attention.

52. In response to Mr Ramasamy KC's submissions, Ms Grey KC explained at the hearing that she did not intend to suggest that the Tribunal had to balance the aggravating and mitigating factors against each other. Her submission was that the aggravating factors were inadequately identified, in contrast to the mitigating factors which were given emphasis and weight by the Tribunal.

53. **Limb 2**. Ms Grey KC submitted that the Tribunal's consideration of the public interest of maintaining confidence in the profession and in upholding professional standards, was restricted to a very short passage in D/111, which was cursory and inadequate. It failed to demonstrate that limbs 2 and 3 of the over-arching objective had been properly considered.

54. **Limb 3**. Ms Grey KC submitted that, at D/112, the Tribunal arrived at a premature conclusion that suspension would not be appropriate before considering the less restrictive course of taking no action, based on exceptional circumstances. It reached a conclusion on proportionality before going on to "justify" it by reference to the exceptional factors.

Mr Ramasamy KC's submissions

55. **Limb 1**. Mr Ramasamy KC submitted that the SG required that the mitigating and aggravating factors were balanced against the central aim of sanctions, not against each other. The factors do not have to be balanced. In this case, there were significant mitigating factors which outweighed the aggravating factors. The Tribunal was not required to restate the findings which it had made at the facts and impairment stages. At D/102 the Tribunal explained that it had taken those matters into account in its deliberations on sanction, and that was sufficient. In *Mehta*, the court warned against

"box-ticking" and stated that the question was whether there had been a proper evaluation of the complaint within its own factual matrix (at [28]).

56. **Limb 2**. Mr Ramasamy KC submitted that it was sufficient for the Tribunal to rely upon its earlier findings. The relevant factors were considered in some detail at D/73–79, at impairment stage. At D/102, the Tribunal stated it had taken its earlier findings into account in its deliberations on sanction and that was sufficient. At D/114–116, the Tribunal applied the guidance at SG/68-70 in reaching its conclusion that no further action was required.

57. **Limb 3.** Mr Ramasamy KC acknowledged the principle, enshrined in the SG, that the appropriate way to approach sanctions is to begin by considering the least restrictive sanction first. However, he submitted that the Tribunal had adopted this approach at D/114-116. The Tribunal's remarks on the appropriateness of conditions and sanctions at D/112 were merely its natural response to the submissions of the parties.

Conclusions

Limb 1

58. SG/24 and SG/50 provide that a tribunal "needs to consider and balance" the mitigating and aggravating factors presented to it "against the central aim of sanctions" as set out in SG/14-16. In my judgment, this means that a tribunal must take into account both the mitigating and aggravating factors when assessing the misconduct and impairment which has been found, in determining what sanction is necessary to meet the three limbs of the over-arching objective.

59. The Tribunal identified the mitigating factors at D/107:

> "107. The Tribunal has identified the following mitigating factors in this case:
>
> • Dr Rezk has developed considerable insight to the extent that the Tribunal has found that it is most unlikely that he will ever behave in a similar way again;
>
> • Dr Rezk has undertaken courses and attended sixteen psychological therapy sessions with Dr Sura, a treating psychologist, to address the causes of his misconduct;
>
> • Dr Rezk made full admissions to the charges at the earliest possible opportunity;
>
> • Dr Rezk has apologised to the GMC, to this Tribunal, to his employers. By his counsel, Ms O'Halloran, he has asked that his apologies set out in letters which he drafted following therapy sessions with Dr Sura be conveyed by the GMC to Ms A and Ms B if it is deemed appropriate. They are included in the bundle.

> • Dr Rezk has expressed remorse for his behaviour;
>
> • The testimonials relied on by Dr Rezk confirm that he has adhered to Good Medical Practice since the events in question. They support the proposition that he has maintained good relations with his colleagues. Indeed the only time when he behaved as found proved was during the period September to December 2020. Other than during that period, his character and professionalism have never been called into question. It is apparent moreover that Dr Rezk has now had the courage to share his situation with members of the medical departments which he has served in the last three years or so.
>
> • Dr Rezk has disclosed the multi-source feedback (MSF) which he has received since January 2020. The MSF will have included observations from nursing staff as well as patients and medical colleagues.
>
> • The following table shows the MSF and relevant references from testimonials which Dr Rezk has received in respect of the rotations which he has undertaken. The Tribunal has presented the testimonials as they have been presented to it;
>
> (table omitted)
>
> • Nearly two and a half years have elapsed since the events in question.
>
> • The matters occurred when Dr Rezk was at an early stage of his training. He had only been living in the UK since November 2017."

60. The Tribunal identified the aggravating factors at D/108:

> "108. As to aggravating factors, Dr Rezk's behaviour amounted to sexual harassment towards Ms A and Ms B. Nevertheless, there are a number of matters which the Tribunal considers relevant. Dr Rezk was known to both Ms A and Ms B. They were not patients, nor vulnerable persons. There was no predatory behaviour. In respect of Ms A, he had communicated with her for a period of time before September to December 2020 in a *"chit chat"* way which was not inappropriate. However, he did continue to text her through Facebook messenger after such time as she made it clear that she wished him to stop. She had asked him to stop after he texted her about masturbating. It was during the period after he was asked to stop that he sent photographs of his genitalia. In respect of Ms B his communications ceased upon her unfriending him on Facebook and then him blocking her. All the communications were via Facebook messenger; there was no direct contact, no touching or physical intimidation."

61. The Tribunal identified sexual harassment as an aggravating factor at the outset, and described Dr Rezk's continued harassment of Ms A after she had made it clear that she wished him to stop, which was plainly an aggravating factor.

62. However, much of D/108 refers to mitigating or neutral factors rather than aggravating factors, such as:

    i) Ms A and Ms B were known to Dr Rezk.

    ii) Ms A and Ms B were not patients nor vulnerable persons.

    iii) There was no predatory behaviour.

    iv) Dr Rezk had previously communicated with Ms A in a way that was not inappropriate.

    v) His communications with Ms B ceased upon her unfriending him on Facebook and then him blocking her.

    vi) All the communications were via Facebook messenger; there was no direct contact, no touching or physical intimidation.

63. I accept the GMC's submission that the Tribunal's consideration of the aggravating factors was inadequate. The Tribunal gave little consideration to the seriousness of the harassment, which was not merely verbal, but included sending photographs of his genitalia. Further aggravating factors were that it was a sustained pattern of behaviour over several months, which was directed at more than one nurse. When Ms A advised him that his behaviour was inappropriate and blocked him, he was undeterred and merely switched his unwanted attentions to Ms B.

64. The Tribunal had earlier found, when considering the issue of misconduct, that "he was concerned to satisfy his own desires and that he was not interested in the fact that his messages were unwelcome to either Ms A or Ms B. Effectively he rode roughshod over their dismay in receiving the messages" (D/65). These factors were not taken into account, as they should have been, when considering aggravating factors. When identifying the aggravating factors, the Tribunal did not consider the impact on his victims, who were upset by his conduct.

65. At earlier stages of the proceedings, the Tribunal found that Dr Rezk failed to respect Ms A and Ms B, in breach of paragraph 36 of *Good Medical Practice* (D/62), and in breach of a fundamental tenet of the profession to treat colleagues with respect (D/77). The guidance in the SG identified mistreatment of colleagues as a serious aggravating factor (SG/55d and SG/138). In my view, these were clearly aggravating factors. Yet the Tribunal did not consider as aggravating factors the importance of maintaining appropriate boundaries with colleagues in the NHS, and enabling colleagues, especially more junior ones, to feel respected and safe in the workplace and with colleagues generally.

66. I am unable to accept Mr Ramasamy KC's submission that it can be assumed that the Tribunal did take into account all these matters as aggravating factors because the Tribunal said, at D/102, that it had taken into account its earlier findings during its deliberations on sanction. A Tribunal is required to identify the mitigating and

aggravating factors as an essential part of the discipline of the decision-making process. This is not mere box-ticking, which was deplored in *Mehta*. It is significant that the Tribunal identified the mitigating factors in considerable detail, but not the aggravating factors. I do not agree with Mr Ramasamy KC's submission that this was because there were very few aggravating factors. In my view, the failure to identify the aggravating factors demonstrated the Tribunal's undue emphasis on the points in Dr Rezk's favour, and its failure to have proper regard to the seriousness of his misconduct, and the over-arching objective.

Limb 2

67. I accept the GMC's submission that the Tribunal's consideration of the public interest of promoting and maintaining confidence in the profession, and proper professional standards and conduct, was not adequately addressed by the Tribunal.

68. At D/111, the Tribunal correctly identified limbs 2 and 3 of the over-arching objective, but then only referred to the finding of impairment already amounting to a significant judgment on Dr Rezk, and that it was in the public interest and consistent with the over-arching objective to enable him to continue with his career.

69. Applying the guidance given in *Chandra*, at [90], the Tribunal ought also to have considered whether public confidence and professional standards would be damaged by not imposing a sanction on Dr Rezk.

70. The Tribunal's earlier findings on impairment at D/73-78 were that Dr Rezk had breached two paragraphs of *Good Medical Practice* and breached a fundamental tenet of the profession, namely, treating colleagues with respect. The Tribunal concluded, at [79]:

> "… the public would be dismayed if it did not make a finding of impairment where behaviour such as this has been proved. It has reached the conclusion that Dr Rezk's fitness to practise is impaired on wider public interest grounds because such a finding is necessary to uphold proper professional standards and conduct and to maintain public confidence in the profession."

71. Contrary to Mr Ramasamy KC's submission, it cannot be assumed that the Tribunal took these findings on impairment into account when considering sanction because of the cross-reference at D/102. The Tribunal had to consider whether, in the light of its earlier findings on misconduct and impairment, public confidence and professional standards would be damaged if no sanction was imposed on Dr Rezk. This is a different issue to that of impairment, and it should have been expressly addressed.

72. The SG states, at SG/68, "[w]here a doctor's fitness to practise is impaired, it will usually be necessary to take action to protect the public (see paragraphs 14-16)". This principle is also reflected in SG/20–21. It should have been the starting point for the Tribunal. However, this principle was simply not addressed by the Tribunal.

Limb 3

73. SG/66 sets out the available sanctions where a MPT finds a doctor's fitness to practise is impaired. It begins with "take no action" as the least restrictive sanction, and progresses to the more severe sanctions of conditions, suspension and erasure.

74. The Tribunal acknowledged the well-established principle that it should consider the available sanctions in order, starting with the least restrictive (at D/110). However, it did not apply this principle. On a fair reading of the Determination, the Tribunal decided at D/111 and D/112 that neither conditions nor suspension were appropriate sanctions. After it had made this decision it then considered whether or not it could take no action, applying the guidance in SG/68-70. The approach which the Tribunal should have taken was to consider first of all whether there were exceptional circumstances to justify taking no action. Unfortunately, the Tribunal's approach meant that, consciously or sub-consciously, it was pre-disposed to find exceptional circumstances because it had already decided that neither conditions nor suspension would be a proportionate sanction. I consider that it is likely that this caused or contributed to the error in assessing exceptional circumstances which is the subject of Ground 2. It was not mere box-ticking, of the type criticised in *Mehta*. It was a significant error in the Tribunal's approach.

75. It follows that I cannot accept the submission of Mr Ramasamy KC that the Tribunal was merely responding to the submissions made to it, and that it did consider the "take no action" option first.

76. For these reasons, Ground 1 succeeds.

Ground 2

Ms Grey KC's submissions

77. On Ground 2, Ms Grey KC submitted that the Tribunal erred in concluding that there were "exceptional circumstances" which justified it in taking no action as the circumstances relied upon by the Tribunal were simply not exceptional and did not justify taking no action.

78. Ms Grey KC also submitted that the Tribunal's approach was inconsistent since at D/66 it concluded that the circumstances relied upon as so exceptional as to justify taking no action were not such as to mitigate his sexual harassment of Ms A and Ms B.

Mr Ramasamy KC's submissions

79. Mr Ramasamy KC submitted that the Tribunal, as a specialist tribunal with one medical member, was best placed to consider whether the impact of the COVID 19 pandemic on Dr Rezk amounted to exceptional circumstances which justified taking no action.

80. He rejected the criticism of inconsistency on the part of the Tribunal, as at D/66 the Tribunal was considering whether the circumstances relied upon by Dr Rezk amounted to mitigation of misconduct, whereas at D/114 the Tribunal was considering the different question of sanction.

81. Mr Ramasamy KC relied on the case of *Mehta* which had similarities to this case, and submitted that this Court should adopt the same approach as the court in *Mehta*.

82. Mr Ramasamy KC also submitted that, despite the Tribunal's decision to take no action, Dr Rezk has the finding of impairment on his record, which is publicly available, and is likely to impact his career prospects and reputation for the next 5 years at least, given the GMC's *'Publication and disclosure policy'*. These proceedings have caused him considerable personal stress, and disruption to his career.

Conclusions

83. In my judgment, although the Tribunal referred to the guidance in SG/68-70, it failed to apply it properly to the facts of this case. In particular, the Tribunal failed to apply the principle that where a doctor's fitness to practice is impaired, it will usually be necessary to take action to protect the public (SG/68). It also misapplied the guidance that "exceptional circumstances" are "unusual, special or uncommon, so such cases are likely to be very rare" (SG/70).

84. I accept the GMC's submission that, at D/114 and D/115, the Tribunal identified as "exceptional circumstances" matters which were not exceptional, and did not justify taking no action.

85. The Tribunal's finding that Dr Rezk has been "a diligent, conscientious and professional doctor on a training programme which he was completing in an exemplary fashion" is not "unusual, special or uncommon". In *Bolton v Law Society*, Sir Thomas Bingham M.R. observed that "[it] often happens that a solicitor appearing before the tribunal can adduce a wealth of glowing tributes from his professional brethren". This is likely to be the case for many doctors appearing before MPTs who are accused of misconduct outside the scope of their professional work.

86. The Tribunal found that, during the COVID 19 pandemic, Dr Rezk felt isolated and unsupported because his family members were in Egypt; he had only been in the UK since November 2017; he lived alone; he had to move around the country on training rotations; he was lonely and could only communicate on the internet. Therefore he did not have the inner resource, and assistance of family and friends to cope with the strain of treating patients in the ICU. In my view, these circumstances were not "unusual, special or uncommon".

87. It is common knowledge that, during the height of the COVID 19 pandemic, the work of thousands of NHS staff became stressful, demanding and upsetting. In that regard, Dr Rezk's experience was not "unusual, special or uncommon".

88. Most junior hospital doctors who wish to progress in their careers have to move around the country on short-term training rotations, often to places where they have

no family or friends, and so are liable to feel isolated or lonely as a result. Both British and overseas doctors (of whom there are many) are required to undertake training rotations. In that regard, there was nothing unusual about Dr Rezk's career path, prior to the fitness to practice proceedings. As Mr Ramasamy KC pointed out, British junior hospital doctors may be able to travel to visit friends and family when they are not on duty. However, during the COVID 19 lockdowns, the ability to visit family and friends was highly restricted for everyone. Furthermore, many people who were exposed to COVID 19 patients in the course of their work avoided visiting family and friends, for fear of infecting them.

89. Unfortunately, loneliness and isolation was a common experience during the COVID 19 pandemic, particularly among those living alone (especially if they were not in work), because of the restrictions on mixing with other people. In my view, it was commonplace and not exceptional for people to communicate more via the internet when face-to-face contact was restricted. I note that in his evidence to the Tribunal (transcript page 83), Dr Rezk said Facebook connected him with his family and friends. He had maybe 1,000 friends on his account and was talking actively to 20 people. He spent about a quarter of the day online, talking to his family and friends in Egypt, and his UK friends (transcript page 76). I observe that he was able to maintain his relationships with family and friends in Egypt – he was not completely cut off from them.

90. The Tribunal placed particular emphasis upon the fact that Dr Rezk arrived in the UK in November 2017 and, at the date of his sexual misconduct, "he had not been living in the UK sufficiently long enough to enable him to conduct himself in a difficult situation appropriately". The "difficult situation" was the pandemic and the training rotations. I find this passage in the Determination ambiguous, but in so far as the Tribunal may have been suggesting that his misconduct was caused or contributed to by cultural differences between Egypt and the UK, to which he had not adjusted during the 3 years he had been in the UK, that conclusion was not supported by the evidence.

91. At the hearing (transcript page 75), Dr Rezk described the pressure in the ICU and said:

> "…I was stressed. Mentally, I think it was good to go to work. We were – lots of people did not have the chance to go and interact because of the isolation ...but, again, this is not an excuse to go and disclose yourself to a colleague and expose them to this and expose myself to this. ….You cannot date, you cannot mingle, you cannot see friends but, again, you need to maintain some self-discipline and conscience towards yourself and your colleagues…."

92. He was asked by a Tribunal member (transcript pp 116-117), how the stress, pressure and loneliness that he described led to the sexual misconduct. His explanations were as follows:

> "….people could not meet as they could have met before Covid and that led to the messages getting more …sexual or more explicit than they have…"

> "….the simple answer to that question, this action of sex is part of what normal human beings perceive when they are – I wouldn't say when they are stressed, it is part of like eating and it is basic human needs. Okay? I think, as I have mentioned, the word unhealthy defence mechanisms led to me thinking that this could be one of them, okay, this could be a channel and the channel went unfortunately into Ms A and Ms B …. I thought at that point of time addressing loneliness ….that this might make her like me more, okay, and then it would lead to some form of relationship …."

93. He was also asked about the cultural differences between the UK and Egypt at the hearing (transcript pp 118-119) and replied:

> "…. well the culture in any country is to respect women and to respect people. Okay? That is the culture I was brought up on. My mum is a doctor. She has been a professional … working herself all this time ….I have done a terrible mistake … "

> "… I was in a mixed school since I was three. It was an English school….that is the culture I have been brought up in, mixed schools, mixed university, ending up in coming to the UK, so no matter of discrimination against women or anything…"

94. Dr Rezk explained that his parents did not know the nature of the case against him and that they would not be happy about it if they knew.

95. In summary, Dr Rezk's explanation for his misconduct was his inappropriate response to the pandemic and its consequences. He was under extreme pressure at work. As he lived alone, he was lonely and isolated and the COVID 19 restrictions prevented him from meeting people, dating and having a normal sexual relationship. His sexual needs were not being met. I consider it is likely that other people without a partner had similar experiences to Dr Rezk during the pandemic, and so I conclude that his circumstances were not "unusual, special or uncommon".

96. I agree with the GMC's submission that the Tribunal's approach to the evidence was inconsistent. When considering the issue of misconduct, the Tribunal found as follows:

> "63. The explanation that Dr Rezk advances for his behaviour was that, although he was 29 years old, he was immature, and that working in the ICU / Anaesthetic department at Walsall Manor Hospital when the covid epidemic was rife was extremely pressurised and stressful for him, both at work and where he lived. At the time he was living alone; he felt isolated; he did not see people socially; his parents were in a different country; he spent a significant period of his days "on-line".
>
> 64. The Facebook Messenger texts which the Tribunal has seen….demonstrate that he was persistently pushing the

> boundaries of what would be appropriate between erstwhile colleagues and that he was interested in discussing sexual matters, notwithstanding that these matters were not encouraged or initiated by Ms A or Ms B…..
>
> 65. The Tribunal accepted that in sending these messages and in the case of Ms A photographs of himself, Dr Rezk demonstrated a significant degree of immaturity. However, the Tribunal was satisfied, as Dr Rezk admitted, that the messaging was sexually motivated. The Tribunal finds that he was concerned to satisfy his own desires and that he was not interested in the fact that his messages were unwelcome to either Ms A or Ms B. Effectively he rode roughshod over their dismay in receiving the messages. He was not able to explain to the Tribunal how he intended that the stress which he was enduring would be alleviated by his conduct towards Ms A and /or Ms B beyond saying it was to do with him being human. Nor did he call any evidence from Dr Sura, a treating Psychologist, to explain his behaviour.
>
> 66. The Tribunal has reached the conclusion that the explanations which Dr Rezk advanced do not mitigate his behaviour which, objectively, amounted to harassment of Ms A and Ms B. To be fair, Dr Rezk admitted misconduct before the Tribunal. The Tribunal therefore concluded that the matters found proved amounted to misconduct which was serious."

97. The factors identified at D/63 were amongst the factors that the Tribunal considered were "exceptional" when considering sanction. It is difficult to understand how such factors can be, simultaneously, insufficient to explain or mitigate the seriousness of what happened, yet "exceptional" when it comes to consideration of sanction.

98. Although Mr Ramasamy KC submitted that the Tribunal, with its specialist experience and one medical member, was best placed to assess the issue of exceptionality, I am satisfied that this is an area in which the Court is less dependent upon the expertise of the Tribunal and can make its own assessment. See Sharp LJ in *Jagjivan*, at [40(vi)].

99. Each case turns on its own facts. In my judgment, this case is clearly distinguishable from *Mehta*, on which Mr Ramasamy KC relied. In *Mehta*, the doctor's personal remediation and insight was not sufficient to amount to exceptional circumstances. The exceptional circumstances arose from the presentations that he gave his colleagues, educating the profession, and reducing the risk of similar behaviour by others. Dr Rezk's case did not include any comparable exceptional circumstances.

100. For these reasons, Ground 2 succeeds.

Conclusions on the appeal

101. For the reasons set out above, I conclude that the decision of the Tribunal was wrong, applying the test in CPD 52.21(3), and accordingly the GMC's appeal is allowed.

Sanctions

102. The powers of the High Court on appeal are set out at subsection (6) of section 40A MA 1983 which provides as follows:

> "(6) On an appeal under this section, the court may—
>
> (a) dismiss the appeal;
>
> (b) allow the appeal and quash the relevant decision;
>
> (c) substitute for the relevant decision any other decision which could have been made by the Tribunal; or
>
> (d) remit the case to the MPTS for them to arrange for a Medical Practitioners Tribunal to dispose of the case in accordance with the directions of the court,
>
> and may make such order as to costs . . . as it thinks fit."

103. At the request of the parties, I announced that I was going to allow the appeal at the end of the oral submissions on 14 November 2023, but counsel asked to see my full judgment before making submissions on sanction. I then circulated a confidential draft judgment setting out my reasons. Counsel filed further skeleton arguments on the powers of the Court under section 40A(6) MA 1983, and the hearing resumed on 29 November 2023.

Ms Grey KC's submissions

104. Ms Grey KC submitted that it was a matter for the Court whether to remit the case to the MPTS or to determine the issue of sanction itself. Referring to the submissions made by the GMC before the Tribunal, she submitted that the appropriate sanction was suspension. A sanction of no further action was not adequate to signal the seriousness of the misconduct and in any event, there were no "exceptional circumstances" to justify such a decision. Conditions would not be appropriate, proportionate, workable or measurable and would serve no purpose. The MPT found that the doctor had developed good insight and that there was a low likelihood of repetition. Conditions were a way of dealing with deficiencies in practice and did not "match" the areas of impairment in this case, which related to public confidence and professional standards rather than personal remediation.

105. Ms Grey KC submitted that the appropriate sanction was a period of suspension which would mark the serious nature of the misconduct and safeguard public confidence in the profession and maintain professional standards. In response to the

concern that suspension would be likely to result in the loss of his training contract and therefore have a disproportionate effect, Ms Grey KC referred to the Gold Guide and the email correspondence which was before the Tribunal and submitted that decisions on termination of training contracts are discretionary, and in the event of loss, there is a reapplication process. In any event, loss of the training contract is not enough to render suspension disproportionate, applying the *Bolton* principles (Judgment [27]) and *Hanna v GMC* (Judgment [28]).

106. Ms Grey KC also referred to the case of *General Medical Council v Patel* [2018] EWHC 171 (Admin) in which HH Judge Dight CBE, sitting as a Judge of the High Court, quashed a MPT determination to take no action after findings of dishonesty against a doctor, largely as a result of concerns about the impact of a suspension order on his training contract. The Judge found that the MPT erred, *inter alia*, in assuming the worst outcome of suspension, which was not the correct analysis of the evidence. The Gold Guide indicated that suspension would not automatically lead to the removal of the training number.

Mr Ramasamy KC's submissions

107. Mr Ramasamy KC asked the Court not to remit the matter to the MPTS because further delay would be stressful for Dr Rezk and potentially cause further professional disruption. He submitted that it remained open to the Court to take no action, on the basis of exceptional circumstances, namely, the stress of the appeal process, the delay in Dr Rezk's career progression, and the favourable references demonstrating his insight and remediation, both before and after the Tribunal hearing.

108. Alternatively, Mr Ramasamy KC invited me to impose conditions on Dr Rezk's registration, and he provided a draft set of conditions, which have been reviewed by a GMC Case Examiner. He submitted that conditions would be an appropriate and proportionate sanction. They imposed significant obligations on Dr Rezk and would be seen by the public and the profession as an ongoing marker of disapproval of his conduct in this case. The order would remain on his record, and be publicly available on the GMC's website, for a period of ten years.

109. Mr Ramasamy KC submitted that the sanction of suspension would now represent a disproportionate response to the misconduct, and referred to the submissions made on behalf of Dr Rezk to the Tribunal. The Gold Guide, at paragraph 3.99(vi), indicates that his training contract "will" be withdrawn in the event of suspension from the medical register. Paragraph 3.108 of the Gold Guide states that speciality training posts and programmes are not normally available to trainees who have been removed from a training post. In order to re-apply, an applicant must have the support of the Postgraduate Dean and must complete a specific form. Re-entry will be by competitive process with other applicants. Mr Ramasamy KC explained that he could not apply to repeat training years that he had already completed.

110. Finally, Mr Ramasamy KC relied upon the public interest in retaining good and committed doctors.

Conclusions

Remittal to MPTS

111. In my judgment, I am in a position to reach a conclusion on the issue of sanctions after having heard and read extensive submissions and evidence, and I consider it is appropriate for me to do so. The misconduct occurred as long ago as 2020, and the Tribunal made its determination on 3 April 2023. If I remit the matter for reconsideration by a fresh MPT, it would have to hold a further hearing, perhaps hear evidence, and then reach a determination. That process is unlikely to be concluded until well into 2024. It would take even longer if the previous Tribunal panel has to be re-convened. In any event, in view of my findings, a fresh panel is more appropriate. The delay has been, and continues to be, detrimental to Dr Rezk. Equally importantly, it is not in the interests of the National Health Service for the training of doctors to be delayed, and it is not in the public interest for extensive resources to be spent on protracted tribunal and court hearings.

Sanctions

112. In approaching the issue of sanction, I have applied the statutory overarching objective in section 1 MA 1983 (Judgment [18]) and considered the relevant case law (Judgment [24] – [32]; [106]). I have also taken into account the Sanctions Guidance, and the relevant case law (Judgment [33] – [49]).

113. The allegations found proved are set out at Judgment [9], and I rely upon the following findings of the Tribunal on the issues of misconduct and impairment.

114. The Tribunal found that Dr Rezk's behaviour was "inappropriate, sexually motivated and amounted to sexual harassment" and was "sufficiently serious to amount to misconduct" (D/59). He was "persistently pushing the boundaries of what would be appropriate between erstwhile colleagues" (D/64) and acted in breach of *Good Medical Practice* (2013) (D/62)

115. The Tribunal found, at D/65:

> "65. The Tribunal accepted that in sending these messages and in the case of Ms A photographs of himself, Dr Rezk demonstrated a significant degree of immaturity. However, the Tribunal was satisfied, as Dr Rezk admitted, that the messaging was sexually motivated. The Tribunal finds that he was concerned to satisfy his own desires and that he was not interested in the fact that his messages were unwelcome to either Ms A or Ms B. Effectively he rode roughshod over their dismay in receiving the messages. He was not able to explain to the Tribunal how he intended that the stress which he was enduring would be alleviated by his conduct towards Ms A and / or Ms B beyond saying it was to do with him being human. Nor did he call any evidence from Dr Sura, a treating Psychologist, to explain his behaviour.

> 66. The Tribunal has reached the conclusion that the explanations which Dr Rezk advanced do not mitigate his behaviour which, objectively, amounted to harassment of Ms A and Ms B."

116. The Tribunal went on to find that Dr Rezk's fitness to practice was impaired on public interest grounds, and that such a finding was necessary to uphold proper professional standards and conduct, and to maintain public confidence in the profession. After weighing up the evidence and submissions, the Tribunal concluded that Dr Rezk failed to treat his NHS colleagues with respect by sexually harassing them. He thereby acted in breach of a fundamental tenet of the profession to treat colleagues with respect (D/76-77).

117. For the purposes of sanction, the mitigating factors identified by the Tribunal were set out at D/107, including a tabular summary of the many favourable reports on his professionalism, personal behaviour and clinical skills. The Tribunal also referred to other factors which were mitigating rather than aggravating in D/108 (see Judgment [62]). At the hearing before me, further evidence has been adduced, namely:

i) A favourable reference from Dr E.R. Williams, Consultant in Emergency Medicine, dated 22 September 2023, who has had oversight of Dr Rezk's training and has been his Educational Supervisor for some of the time. This was supplemented by a copy of the Faculty Educational Governance Statement for Dr Rezk.

ii) A letter from Dr Moe Thaw Oo, Deputy Head of Academy, dated July 2023, setting out favourable feedback on Dr Rezk from undergraduate students.

iii) A favourable Multi-Source Feedback on Dr Rezk dated 19 September 2023.

118. As to aggravating factors, Ms Grey KC correctly submitted that the Sanctions Guidance adopts a broad approach at SG/55-56. The Tribunal identified sexual harassment as an aggravating factor at D/108, and described Dr Rezk's continued harassment of Ms A after she had made it clear that she wished him to stop, which was plainly an aggravating factor.

119. In my judgment, I also identified as aggravating factors:

i) The seriousness of the harassment, which was not merely verbal, but included, in the case of Ms A, sending photographs of his genitalia.

ii) Dr Rezk was engaged in a sustained pattern of behaviour over several months, which was directed at more than one nurse. When Ms A advised him that his behaviour was inappropriate and blocked him, he was undeterred and merely switched his unwanted attentions to Ms B.

iii) He was concerned to satisfy his own desires, and he was not interested in the fact that his messages were unwelcome to either Ms A or Ms B.

iv) Ms A and Ms B were upset by his conduct. They too were experiencing the additional workload and stress caused by the pandemic, and then had to cope with Dr Rezk's unwanted attentions as well.

v) Dr Rezk failed to respect Ms A and Ms B, in breach of paragraph 36 of *Good Medical Practice* (D/62), and in breach of a fundamental tenet of the profession to treat colleagues with respect (D/77). The guidance in the SG identifies mistreatment of colleagues as a serious aggravating factor (SG/55d and SG/138b).

120. In considering what sanction to impose, I have applied SG/20 – 21 which states as follows:

> "**Taking a proportionate approach to imposing sanctions**
>
> "20 In deciding what sanction, if any, to impose the tribunal should consider the sanctions available, starting with the least restrictive. It should also have regard to the principle of proportionality, weighing the interests of the public against those of the doctor (this will usually be an impact on the doctor's career, e.g. a short suspension for a doctor in training may significantly disrupt the progression of their career due to the nature of training contracts).
>
> 21 However, once the tribunal has determined that a certain sanction is necessary to protect the public (and is therefore the minimum action required to do so), that sanction must be imposed, even where this may lead to difficulties for a doctor. This is necessary to fulfil the statutory overarching objective to protect the public."

No action

121. The least restrictive sanction available is "take no action" (SG/68-70). In addition to the material which was before the Tribunal, Mr Ramasamy KC relied upon the stress of the appeal process, the delay in Dr Rezk's career progression and the favourable references demonstrating his insight and remediation, as exceptional circumstances which justify taking no action. For the reasons set out in Judgment [83] – [99], I do not consider that there are exceptional circumstances in this case. In my experience, the post-Tribunal factors relied on by Mr Ramasamy KC are not unusual in professional disciplinary proceedings.

122. Furthermore, in my judgment, taking no action in this case would not meet the overarching objective of protection of the public, in that it would not promote and maintain public confidence in the medical profession or proper professional standards and conduct for members of the profession. It would appear unduly lenient.

Conditions

123. The next least restrictive sanction available is an order imposing conditions on a doctor's practice, for a period of up to 3 years.

124. The Tribunal rejected this sanction as disproportionate in the light of its finding that Dr Rezk had addressed his shortcomings and had nothing more to achieve by way of

remediation (D/112). When considering impairment, the Tribunal found that he had undertaken a number of CPD courses, though only after the complaints were made, which addressed *inter alia* professional boundaries. He also attended 16 psychological therapy sessions with a psychologist, Dr Sura. The Tribunal considered that he had gained considerable insight into his behaviour and it was most unlikely he would behave in a similar way again. Therefore his fitness to practise was no longer impaired on purely public protection grounds (D/69 – 72).

125. In my view, the evidence indicated that Dr Rezk displayed very inappropriate attitudes towards women, including female colleagues, which he had addressed through courses and therapy in the year or so before his Tribunal hearing. The question for me to decide was whether he needed to continue with remedial work for a longer period to meet the overriding objective.

126. The GMC correctly submitted to the Tribunal that Dr Rezk initially minimised his own actions and behaviour, and it is instructive to see how he responded to the complaints. In the Rule 7 response, dated 7 April 2022, he dismissed his exchanges with Ms A as "harmless banter and flirting" and "light- hearted, jovial and jokey". He said that he was "very fond of her" and "must have misread [her] level of engagement with him". There was no recognition of the seriousness of his behaviour, and its likely impact upon Ms A.

127. By the date of the Tribunal hearing, with the benefit of courses and therapy, Dr Rezk had gained more insight. In his evidence to the Tribunal, when asked why he persisted in making sexual advances when Ms A had asked him not to do so, he said: "there is this false ego of 'I do not want to be refused' or 'I am feeling very painful to be refused', hence the defence … mechanism of denial" (Transcript Day 2, p.78; D/28). In my view, Dr Rezk's denial, and his inability to accept that Ms A did not reciprocate his sexual interest, because of his "false ego", is an indicator of risk in Dr Rezk's interaction with females generally. Recognition of his sub-conscious response is an essential first step, but controlling and eliminating that response is likely to be slower and more difficult.

128. The Tribunal recorded, at D/69:

> "He explained that the trigger for his seeking psychological assistance was his being reported to the GMC in respect of another matter in the early part of 2022 …. He stated that he finally realised that this case was to do with himself, who he was and that he needed to address his shortcomings if he was to continue to be a doctor in the UK."

129. Regrettably, Dr Rezk did not provide the Tribunal with a report from Dr Sura, on the grounds that he did not want to reveal personal matters. If he had done so, the Tribunal might have been in a better position to assess whether further psychological work was required. Dr Rezk said he no longer needed to see his psychologist as "he knew what his "red buttons" were so as not to allow such behaviour to happen again" (D/33). However, there was evidence that his psychological work was incomplete, for example, he had not yet felt able to comply with Dr Sura's recommendation that he ought to make full disclosure of the allegations to his parents and his fiancée.

130. The Tribunal considered it likely that he was motivated to attend the courses and undertake psychological therapy because of his forthcoming appearance before the MPT, his shame at the proceedings, and his commitment to his career. In my view, that is likely to be the case. It raises the question whether, once those pressures are no longer present, he will have any incentive to work on his attitude towards female colleagues.

131. In determining sanction, I take a more cautious approach than the Tribunal, which was content to take no action. I consider that the Tribunal failed to give any or any sufficient consideration to the possibility that Dr Rezk's conduct stemmed from deep-seated inappropriate attitudes towards women, including colleagues, which could benefit from further remedial work, under supervision. In my view, it would not be disproportionate to impose conditions to address this concern.

132. Dr Rezk's representatives have proposed to the Tribunal, and to this Court that conditions should be imposed which require:

i) Notification to the GMC of details of his current and future posts and any disciplinary proceedings;

ii) Within 3 months of the conditions becoming effective, Dr Rezk is to design a personal development plan ("PDP") with specific aims to address the deficiencies in the following areas of his practice:

a) Treating colleagues with respect and ethics;

b) Good Medical Practice – Ethical Guidance, with a focus on paragraphs 35, 36, 37, 65 and 69;

c) General Medical Council's guidance on Doctors' use of social media.

iii) The PDP is to be approved by the responsible officer and sent to the GMC on request;

iv) Dr Rezk must meet with his responsible officer as required, to discuss his achievements against the aims of his PDP;

v) Appointment of an educational supervisor and a workplace reporter; and

vi) Notification of the conditions to relevant bodies.

133. In my view, such conditions come within the scope of the guidance on conditions in the SG. The SG advises:

i) "Conditions might be most appropriate in cases "where there is evidence of shortcomings in a specific area … of the doctor's practice"" (SG/81c). The shortcomings in this case are identified in the scope of the proposed PDP.

ii) Conditions are likely to be workable where (a) the doctor has insight; (b) a period of retraining and/or supervision is likely to be the most appropriate way of addressing the shortcomings; (c) the tribunal is satisfied the doctor will

comply with them; (d) the doctor has potential to respond positively to remediation or training (SG/82).

In my view, all these criteria are met.

134. In my judgment, conditions which require Dr Rezk to continue to work on his attitude towards his female colleagues, under supervision, are an appropriate way of addressing his shortcomings in this regard, and reinforcing the progress that he has already made. In my view, a period of 12 months is the minimum period required to achieve this objective. The Tribunal found that Dr Rezk has insight and has responded positively to remediation or training. In the light of his co-operation with the GMC proceedings to date, I am satisfied that he would comply with any conditions.

135. Such an order would also meet the public interest in training and retaining competent doctors. The other sanctions proposed – no further action or suspension – do not provide for any remediation. Imposition of conditions does not carry with it the risk that he will lose his training contract, which I consider would be a disproportionate response to his misconduct.

136. I accept Mr Ramasamy KC's submission that the sanction of conditions should not be seen as letting Dr Rezk off lightly. The proposed conditions carry obligations, and impose burdens to take positive action, in addition to Dr Rezk's heavy professional commitments. The conditions also impose restrictions since Dr Rezk must inform the GMC about his working arrangements and inform a range of professional colleagues about the conditions. He cannot work until a suitable workplace reporter and educational supervisor have been appointed. The conditions allow the GMC to monitor compliance and progress.

137. I accept the GMC's submission that, in the light of my finding at Judgment [131], and the guidance at SG/163-164, a review should take place before the 12 month period of conditions comes to an end, to consider the remedial work done and whether or not there is a case for any further work.

138. In my judgment, the sanction of conditions would be seen by the public and the profession as an ongoing marker of disapproval of Dr Rezk's misconduct (taking into account the mitigating and aggravating factors), whilst providing a constructive response to his shortcomings. The decision in this case, and the conditions imposed, will remain on Dr Rezk's record, and be publicly available on the GMC website for ten years from the date when the sanction expires. Therefore, I consider that the conditions meet the overarching objective of protection of the public, in that they promote and maintain public confidence in the medical profession and proper professional standards and conduct for members of the profession. In my view, conditions are a proportionate sanction which strike an appropriate balance between the interests of Dr Rezk and the public interest.

Suspension

139. As I have decided that imposing conditions would be an appropriate and proportionate sanction, in accordance with the guidance in SG/20, I should not go on to consider the

more severe sanction of suspension as an option.

140. However, I set out below my reasons for not accepting the GMC's submission that a period of suspension is the only appropriate sanction in this case.

141. I have had regard to the guidance on suspension at SG/91 – 97. Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension also has a punitive effect though this is not its intention (SG/91). Suspension will be an appropriate response to serious misconduct which falls short of conduct which is fundamentally incompatible with continued registration, for which erasure is more likely to be appropriate (SG/92). Also where there has been acknowledgment of fault and the tribunal is satisfied that the behaviour is unlikely to be repeated (SG/93).

142. The GMC has not sought to argue that Dr Rezk should be erased from the register. It has not disagreed with the Tribunal's assessment of Dr Rezk (at D/114) as a "diligent, conscientious and professional doctor" who is part-way through a training programme to become a Consultant in Emergency Medicine which it appears that he is completing in an "exemplary fashion", but considers that cannot be the determinative factor, applying the *Bolton* principle (see also *Hanna*). The GMC accepts that, in determining sanction, the public interest in retaining competent doctors is a factor to be taken into account. However, it has proposed a sanction that does not offer any training or remediation to Dr Rezk to address his shortcomings, when there is an alternative sanction – imposition of conditions – which does potentially offer remediation.

143. Furthermore, after close examination of the evidence with the assistance of both counsel, I am satisfied that there is a real risk that a suspension will result in the loss of Dr Rezk's training contract. If and insofar as HH Judge Dight took a different view in *GMC v Patel*, I respectfully disagree with his assessment. The Gold Guide directive to the Post-Graduate Dean requires "withdrawal of the training number/contract … if the criteria in paragraph 3.99 i – viii are met". Paragraph 3.99 provides:

> "The training number/contract **will** be withdrawn *[emphasis added]* when a trainee:
>
> …..
>
> (vi) has their name erased or suspended from the medical register, or where restrictions are applied to their registration and where such measures are incompatible with continuing in a medical training programme at their level of training
>
> ….."

144. Paragraph 3.101 provides for a right of appeal against removal of a training number or contract. It seems unlikely that Dr Rezk would have grounds for a successful appeal against an adverse decision.

145. The email exchanges between the GMC and the Deputy Dean, Dr Whallett, confirmed that trainees suspended for a period of less than 2 years were considered on a "case by case basis", but that "where an employer …. terminates the doctor's contract following suspension by the GMC for less than 2 years, we have then withdrawn the training number in previous cases". As I understand it, Dr Rezk's employer is the health authority, and he has a separate training contract with the Deanery.

146. If Dr Rezk's training contract is terminated, he can re-apply for a training contract after his suspension, but he is likely to face significant difficulties in doing so. Paragraph 3.108 of the Gold Guide provides:

> "Foundation and speciality training posts and programmes are not normally available to trainees who have …. been released/removed from a training post/programme in that specialty …. However, provided that there are no outstanding fitness to practise issues, unresolved concerns or factors that affect suitability for foundation or specialty training, it is open to those who have had their training number/contract ….. withdrawn …. to reapply to speciality/foundation training at a later date."

147. Dr Rezk would have to obtain the support of the Postgraduate Dean in order to re-apply. Re-entry would be in a highly competitive process with other applicants who are applying to progress from ST3 training contracts to ST4 training contracts in Emergency Medicine, but who do not have the 'black mark' of a GMC suspension on their record and an interruption in training. He would not be eligible to apply to repeat training years which he has already completed. This could mean that he never succeeds in getting back onto an Emergency Medicine specialist training programme. He would not be able to become a consultant, but he could seek employment as a hospital staff doctor.

148. I readily accept that, if it is necessary to suspend Dr Rezk to meet the overarching objective, then the likely damage to his career prospects should not deter me from doing so, applying the *Bolton* principle and SG/21. However, for the reasons I have already given, I do not consider that it is necessary to suspend Dr Rezk in order to meet the overarching objective, as the imposition of conditions is an appropriate alternative sanction. Moreover, suspension would be a disproportionate sanction because of the likely impact on Dr Rezk's training programme. This is the example given in SG/20 which states that a tribunal:

> "should also have regard to the principle of proportionality, weighing the interests of the public against those of the doctor (this will usually be an impact on the doctor's career, e.g. a short suspension for a doctor in training may significantly disrupt the progression of their career due to the nature of training contracts)."

149. For these reasons, I conclude that the sanctions of no action or suspension are not appropriate, and the imposition of conditions is the appropriate sanction in this case.

Final conclusions

150. The GMC's appeal is allowed. The Tribunal's determination, on 3 April 2023, that no action should be taken in respect of Dr Rezk's misconduct and impairment of fitness to practise, is to be quashed. Instead, conditions are to be imposed on Dr Rezk's registration, in terms of the agreed draft presented to the Court by the parties, for a period of 12 months.