PUBLIC RECORD

Dates: 10/02/2025 - 13/02/2025; 01/05/2025 - 12/05/2025

Doctor:	Dr Mohamed RAMADAN
GMC reference number:	7704608
Primary medical qualification:	MB ChB 2013 Alexandria University

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

Summary of outcome

Erasure

Immediate order imposed

Tribunal:

Legally Qualified Chair	Ms Amarjit Sagar
Registrant Tribunal Member:	Dr Iftikhar Ahmed, Dr Jill Edwards

Tribunal Clerk:	Ms Hinna Safdar

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Christopher Mellor, Counsel instructed by Weightmans
GMC Representative:	Ms Chloe Fordham, Counsel

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts & Impairment - 08/05/2025

1. This determination will be handed down in private. However, as this case concerns Dr Ramadan's misconduct, a redacted version will be published at the close of the hearing.

Background

2. Dr Ramadan qualified in 2013 from Alexandria University in Egypt. He moved to the UK in 2019 and worked at Kettering General Hospital ('KGH') for two years. At the time of the events, Dr Ramadan was working at Mount Pleasant Medical Centre ('the Practice'), as a Year 1 GP Trainee in the Southwest and Peninsula Deanery.

3. The Allegation is that, in March 2022 Dr Ramadan consulted with Patient A and, between 19 March and 12 April 2022, he pursued a sexual and improper emotional relationship with Patient A who was vulnerable.

4. It is further alleged that Dr Ramadan inappropriately accessed Patient A's GP and hospital records on 20 March, 24 March and 25 April 2022.

5. The initial concerns were raised with the GMC on 14 September 2022 by his Responsible Officer, Dr B.

The Outcome of Applications Made during the Facts Stage

6. The Tribunal granted an application made on behalf of Dr Ramadan through his Counsel, Mr Chris Mellor, pursuant to Rule 29 (2) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to adjourn to the following day to allow Dr Ramadan some time to prepare himself to give evidence. The Tribunal heard that he had recently flown back to the UK from Egypt.

The Allegation and the Doctor's Response

7. The Allegation made against Dr Ramadan is as follows:

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

1. You consulted with Patient A on the dates set out in Schedule 1 and between 19 March 2022 and 12 April 2022 you pursued:

   a. a sexual relationship with Patient A; **Admitted and found proved**

   b. an improper emotional relationship with Patient A. **Admitted and found proved**

2. You knew at the time of your conduct at paragraph 1 that Patient A was vulnerable as set out at Schedule 2. **Admitted and found proved**

3. You inappropriately accessed Patient A's:

   a. GP records on 24 March 2022; **Admitted and found proved**

   b. hospital records on:

      i. 20 March 2022; **Admitted and found proved**

      ii. 25 April 2022. **Admitted and found proved**

~~4. In the alternative to paragraph 3bii, you failed to record that you had accessed Patient A's hospital records on 25 April 2022 for the purpose of checking whether a psychiatric referral had been actioned.~~

Alternative withdrawn

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

The Admitted Facts

8. At the outset of these proceedings, through his counsel, Mr Chris Mellor, Dr Ramadan made admissions to all paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as

amended ('the Rules'). In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

Impairment

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

The Evidence

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

- Ms C, the Head of Information Governance and Data Protection Officer at Royal Devon University Healthcare NHS Foundation Trust ('the Trust'), dated 6 August 2024
- Mr D, the practice manager for the Practice, dated 10 September 2024

11. Dr Ramadan provided his own witness statement, dated 25 January 2025 and also gave oral evidence at the hearing. In addition, the Tribunal received evidence from the following witnesses on Dr Ramadan's behalf:

- Mr E, consultant surgeon in Trauma and Orthopaedics at KGH, Dr Ramadan's clinical supervisor
- Ms F, a trauma nurse practitioner at KGH

12. XXX

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

- Report of Dr G, a GP and GMC Expert witness, dated 11 September 2024
- Email from the Trust confirming Dr Ramadan's placements, dated 9-10 January 2024
- Audits of Dr Ramadan's accessing of Patient A's hospital and GP records
- Email chain between GP surgery and Trust for details of Dr Ramadan's consultations with Patient A, dated 7 November 2022

- Email chain between GP surgery and Trust regarding accessing of records, dated 24-25 April 2023
- GMC referral, dated 14 September 2022
- Email from Police to the GMC, dated 18 October 2023, attaching:
    - Extraction report of Dr Ramadan's
    - mobile phone and Facebook messages between Dr Ramadan and Patient A
- Extracts from Patient A's medical records
- XXX
- XXX
- XXX
- XXX
- Certificates of Completion including:
    - Maintaining Professional Boundaries
    - Confidentiality for clinical staff in GP practice
    - Confidentiality for hospital doctors, and Reflections on the same
    - CSTF Safeguarding Adults – Level 3, and Reflection on the same
    - Safeguarding Children – Level 1, and Reflection on the same
    - Safeguarding Children – Level 2, and Reflection on the same
    - Safeguarding Children – Level 3, and Reflection on the same
- 33 Testimonials.

Submissions

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

14. Ms Chloe Fordham, Counsel for the GMC, initially cited Good Medical Practice (2024) ('GMP'), however subsequently referenced paragraphs from the 2013 guidance when invited to do so by the Tribunal. She submitted that Dr Ramadan's actions constitute serious misconduct, breaching fundamental principles of GMP (2013). Specifically, paragraph 27, XXX, 53, 55 and 70.

15. Ms Fordham submitted that Dr Ramadan used his professional position to pursue an improper sexual relationship with Patient A (paragraph 53), and when Patient A suffered harm and distress, he failed to put things right (paragraph 55). She stated that Dr Ramadan failed to consult his supervisor about XXX, he failed to consider the needs of a patient who was vulnerable (paragraph 27) and that he exploited Patient A's vulnerability (paragraph 70).

16. Ms Fordham referred the Tribunal the GMC's 2023 'Guidance on Maintaining Personal and Professional Boundaries' and stated that whilst this guidance postdates the date of Dr Ramadan's conduct, it nevertheless emphasises that such conduct has always been unacceptable, even before formal guidance was published. She stated that doctors ought to be aware of and sensitive to such matters. She referenced relevant paragraphs and highlighted that some patients are likely to be more vulnerable than others because of their current circumstances. Further, "*the more vulnerable someone is, the more likely it is that having a relationship with them would be an abuse of power and your position as a medical professional*". She stated that the guidance made it clear that a Doctor must never make a sexual advance or display sexual behaviour towards a patient. Lastly, Ms Fordham referred the Tribunal to GMC guidance on 'Confidentiality: Good Practice in Handling Patient Information', citing paragraph 120 which states that "*You must not access a patient's personal information unless you have a legitimate reason to view it."*

17. Ms Fordham submitted that Dr Ramadan's misconduct was aggravated by several factors: Dr Ramadan initiated contact with Patient A via Facebook and went to her house and engaged in sexual activity with her on the same day, exploiting her vulnerability as a patient seeking mental health support. His actions were not just a one-off error of judgement but a prolonged course of conduct over a period of three weeks. Further, he attempted to destroy evidence by deleting some of the messages and, after Patient A made a complaint, inappropriately accessed her medical records. She submitted that each of the allegations thereby amounted to serious professional misconduct.

18. Ms Fordham submitted that Dr Ramadan's fitness to practise is currently impaired for reasons of public protection and professional standards. Past conduct is a key indicator of future behaviour (*Meadow v GMC [2007]),* and that all four of Dame Janet Smith's criteria (from the Fifth Shipman Inquiry) are engaged: Dr Ramadan poses a risk to patients, has brought the profession into disrepute, and has breached fundamental tenets of medical ethics. She stated that factor (d) was also engaged but only insofar as this relates to Dr Ramadan's integrity and moral principles rather than his honesty.

19. Given the sexual nature of the misconduct, Ms Fordham submitted that remediation carries less weight than in cases of clinical error (*Yeong v GMC [2009]).* The public interest demands a clear declaration that such behaviour is unacceptable, irrespective of Dr Ramadan's efforts at reflection and remediation. Without a finding of impairment, there is a risk that the public could perceive the profession as tolerating serious boundary violations.

20. With regards to insight and remediation, Ms Fordham acknowledged that Dr Ramadan has undertaken professional boundaries training which is to his credit. However, his conduct was not a single error of judgment but a sustained pattern of inappropriate behaviour, including continued contact with Patient A as well as accessing her records after her complaint. She added that there can be no doubt that Dr Ramadan was acutely aware, at the time of the incidents, that his actions constituted a breach of professional boundaries in a number of ways.

21. Ms Fordham further added that the Court in *Yeong* emphasised that in cases of sexual misconduct, remediation efforts are less significant than in clinical negligence cases. She submitted that the primary concern in this case is public confidence, and a finding of impairment is therefore necessary to reaffirm professional standards.

22. Ms Fordham invited the Tribunal to consider that XXX may have contributed to his XXX decision-making. However, this does not diminish the objective seriousness of his misconduct, which is to be assessed against professional standards rather than XXX at the time.

23. Ms Fordham submitted that the ongoing risk posed by XXX is of greater concern. XXX. He failed to disclose XXX and continued to work XXX. His partial insight into XXX do not sufficiently mitigate concerns about future recurrence. Further, Ms Fordham submitted that XXX is more likely than not to impact upon the risk that he presents in the future as when he is XXX, he is prone to act in ways which he later comes to regret.

24. Ms Fordham therefore concluded that Dr Ramadan's fitness to practise is currently impaired due to the gravity of his misconduct, the need to uphold public confidence, and the ongoing risk of repetition posed by XXX. A finding of impairment is therefore necessary to protect patients and maintain trust in the medical profession.

<u>On behalf of Dr Ramadan</u>

25. Mr Chris Mellor, Counsel, submitted that Dr Ramadan has fully admitted all allegations against him from the outset of the proceedings, demonstrating an acceptance of responsibility for his actions. He acknowledges that his conduct—particularly pursuing a sexual and improper emotional relationship with a vulnerable patient (Patient A)—constitutes serious misconduct, breaching fundamental professional boundaries. In his witness statement and reflections, he expresses regret, recognising that his actions violated

ethical principles, undermined patient trust, and compromised the integrity of the doctor-patient relationship.

26. Regarding the inappropriate access of Patient A's medical records, Mr Mellor submitted that Dr Ramadan accepts that his actions were unjustifiable, even if initially motivated by clinical or educational reasons. He now acknowledges that once an improper relationship had begun, he should have had no further involvement in her care and was not entitled to access her records.

27. Mr Mellor emphasised that Dr Ramadan does not dispute that his fitness to practise is currently impaired, given the gravity of his past misconduct. He accepts that the Tribunal may reasonably find impairment based on the egregious nature of his boundary violations (*Cheatle v GMC),* the public interest in upholding professional standards (Dame Janet Smith's criteria), and XXX, although this has not been formally alleged.

28. However, Mr Mellor highlighted key factors suggesting that this misconduct is unlikely to reoccur once XXX. He submitted that XXX. Further, XXX were exacerbated by personal crises namely XXX and isolation during the COVID pandemic.

29. Mr Mellor set out that Dr Ramadan had an unblemished professional record prior to these events and has had multiple colleague testimonials, including from consultants and nurses, to attest to his professionalism, empathy, and respect for boundaries in past roles. Mr Mellor submitted that the misconduct was entirely out of character, with no prior pattern of similar behaviour. He added that Dr Ramadan has fully admitted his wrongdoing, has apologised to Patient A and the Tribunal, and reflected on the harm caused to the patient, his colleagues and the medical profession. He has completed courses on professional boundaries, confidentiality, safeguarding, and General Data Protection Regulation ('GDPR'), with detailed reflections on lessons learned. Mr Mellor acknowledged that Dr Ramadan's engagement with XXX was delayed, due to XXX. However, Mr Mellor reminded the Tribunal that Dr Ramadan has now XXX and is committed to XXX. As such, Mr Mellor submitted that the this demonstrates that Dr Ramadan's past misconduct will not be repeated.

30. While Dr Ramadan accepts a finding of impairment is justified, Mr Mellor emphasised that the misconduct was an isolated incident, strongly linked to XXX at the time, there is no evidence of a recurring risk once XXX. Further, Dr Ramadan's insight, regret, and remediation efforts would support his eventual safe return to practise.

The Relevant Legal Principles

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

32. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct and whether the misconduct, if found, was serious and then whether any such misconduct found should lead to a finding of impairment.

33. The Tribunal must determine whether Dr Ramadan's fitness to practise is impaired today, taking into account Dr Ramadan's conduct at the time of the events, the context of that misconduct and any relevant subsequent factors including whether the misconduct found is remediable, whether it has been remedied and the likelihood of repetition. It should also have regard to the public interest in upholding the reputation of the profession and declaring and upholding standards of conduct for members of the profession.

34. The Legally Qualified Chair ('LQC') highlighted the case of *Roylance v GMC (no2) (2000) 1 AC 311* (UKPC) which states:

"Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a [medical] practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word professional which links the misconduct to the profession [of medicine]. Secondly, the misconduct is qualified by the word serious. It is not any professional misconduct which would qualify. The professional misconduct must be serious."

35. The LQC referred to the case *Nandi v GMC [2004] EWHC 2317 (Admin)*, in which it was said that serious misconduct is sometimes described as *"conduct which would be regarded as deplorable by fellow practitioners"*.

36. The LQC also referred to *Howden v Bar Standards Board, [2017] EWHC 210 admin*, that it is a high threshold and that to amount to serious misconduct, the conduct in question must be reprehensible, morally culpable or disgraceful.

37. There is no statutory definition of impairment. The Tribunal was assisted by the guidance provided by Dame Janet Smith in the Fifth Shipman Report, as adopted by the High Court in *CHRE v NMC and Paula Grant [2011] EWHC 297 Admin*. In particular, the Tribunal considered whether its findings of fact showed that Dr Ramadan's fitness to practise is impaired in the sense that he:

a. *'Has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
b. *Has in the past and/or is liable in the future to bring the medical profession into disrepute; and/or*
c. *Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
d. *Has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

38. The LQC reminded the Tribunal of the need to take into account the overarching objective which is to protect the public and 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.*

39. However, there may be cases where the nature of the misconduct may be such that it leads to a finding of impairment in order to maintain public confidence in the profession by reinforcing the standards expected of registered medical practitioners, and in such cases, remedial action may be far less significant and given considerably less weight as was stated in the case of *Yeong v GMC 2010.*

40. XXX

41. As per *Professional Standards Authority for Health and Social Care v the General Optical Council (rose 2021 EWHC 2888 admin*), insight is an essential prerequisite to a confident conclusion that a problem has been properly understood, addressed, and eliminated for the future. In looking at remediation, the Tribunal must look at the objective remedial steps taken by the doctor. The worse the doctor's failings and the more disastrous the ultimate outcome, the greater the need for public reassurance about the future.

The Tribunal's Determination on Impairment

Misconduct

42. In reaching its decision on misconduct, the Tribunal noted that the submissions made on behalf of both the GMC and Dr Ramadan were to the effect that his actions did amount to serious misconduct. While there was agreement between the parties, the Tribunal exercised its own judgment.

43. Although it was initially referred to GMP 2024 GMP, it did not consider these and referred to those later cited by Ms Fordham from GMP 2013. To do so would be unfair on Dr Ramadan as the maintaining professional boundaries is only specifically defined in the new guidance and not that which would be applicable on the date of this conduct. Similarly, the Tribunal did not consider the newer GMC guidance for Maintaining Professional Boundaries however, acknowledged that Dr Ramadan would have been aware at the time of his obligation to maintain professional boundaries.

44. The Tribunal had regard to paragraphs 27, 53, 65 of GMP, which provide:

> *'27 Whether or not you have vulnerable adults or children and young people as patients, you should consider their needs and welfare and offer them help if you think their rights have been abused or denied.*
>
> *53 You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.*
>
> *65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.'*

Paragraph 1(a) and (b)

45. The Tribunal had regard to the report produced by Dr G, incorporating Dr Ramadan's notes of the consultation with Patient A on 17 March 2022. Dr Ramadan's medical records state XXX

46. Dr Ramadan saw Patient A at a face-to-face consultation where he took a history of her anxiety and XXX that she had been experiencing; he prescribed medication for her. Two days after his consultation with her, he sent her a friend request on Facebook and within

eight hours of befriending her on Facebook, he travelled to her home and engaged in a sexual relationship with her. Based on the evidence the Tribunal heard, it was evident that Dr Ramadan only knew Patient A as he recognised her as his patient, having seen her only two days prior in the GP surgery. This is evident in the Facebook messages, which were initially flirtatious, where Patient A refers to Dr Ramadan as '*doc*'. Dr Ramadan was trusted by Patient A as her doctor, she relayed the difficulties she was facing to him with the intention of being helped by him. The Tribunal formed the view that Dr Ramadan, despite knowing that Patient A was extremely vulnerable, as she had described that she was suffering with anxiety, controlling her anxiety by XXX or sexual activity, was living alone, and struggling with alcohol dependency, pursued a relationship with her. It was clear to the Tribunal that Dr Ramadan intended for this to develop to a sexual level. The Tribunal was of the view that Dr Ramadan's behaviour constituted a significant breach of paragraph 53 of GMP and amounted to misconduct. In engaging with Patient A in this way, Dr Ramadan fundamentally breached the doctor patient relationship, and this would be considered as deplorable by fellow medical practitioners. The Tribunal further determined that there was a clear power imbalance as Dr Ramadan was in charge of Patient A's care and used his position as a doctor to form a sexual relationship with her. The Tribunal found that Dr Ramadan's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to serious misconduct.

47. Accordingly, the Tribunal found that Dr Ramadan's action in relation to paragraph 1 (a) and (b) of the Allegation amounted to misconduct.

Paragraph 2

48. Dr Ramadan himself accepted in his evidence that he was fully aware that Patient A was vulnerable at the time of him treating and initiating a relationship with her. He says in his witness statement, dated 29 January 2025.

> *"I am mortified by my actions and I apologise wholeheartedly to both Patient A, who I accept that I knew was vulnerable given her mental health history…"*.

49. Based on this, the Tribunal could be satisfied that Dr Ramadan knew what was expected of him as a doctor towards a vulnerable patient and yet he proceeded to pursue Patient A without any regard to her needs or welfare. This, the Tribunal considered, was a breach of paragraph 27 of GMP.

50. The Tribunal considered, in the round, Dr Ramadan's actions constituted a breach of trust, both to Patient A as an individual patient and further from the public perception of doctors, if patients with mental health issues were being pursued by their primary care physicians. The Tribunal was of the view therefore that Dr Ramadan's behaviour breached paragraph 65 of GMP.

51. The Tribunal acknowledged that by January 2022, Dr Ramadan had become overwhelmed by personal and professional stressors in his life such as XXX. He had moved to becoming a general practitioner, he was not getting along well with people at his workplace as he had a complaint XXX against him, he was not completing his educational portfolio to the level expected by his supervisors. Further, the Tribunal noted that Dr Ramadan stated in his witness statement that during the time of communicating with Patient A on Facebook, XXX was not responding to his text messages, but Patient A was. The Tribunal acknowledged that Dr Ramadan was facing difficulties at the time however, this could not mitigate his disregard of Patient A's vulnerability when engaging in a sexual relationship with her. The Tribunal concluded that this was a significant breach of trust and was nothing less than deplorable.

52. Accordingly, the Tribunal found that Dr Ramadan actions in relation to paragraph 2 of the Allegation amounted to misconduct.

Paragraph 3(a), (b) and (c)

53. The Tribunal went on to consider whether Dr Ramadan inappropriately accessing Patient A's GP records on 24 March 2022 and hospital records on 20 March and 25 April 2022, amounted to misconduct.

54. The Tribunal did not hear any plausible explanation from Dr Ramadan as to why he would be looking at Patient A's records during that time on those dates, he stated he could not recall why. He put forward possible clinical or education reasons for accessing these but accepted he should not have done this whilst in a relationship with Patient A.

20 March 2022

55. On 20 March, Dr Ramadan used his hospital access to look at Patient A's record when he was working as a GP at Mount Pleasant Medical Practice. As such, he was not permitted to use this system to access Patient A's records for clinical or educational purposes. The Tribunal formed the view that this was a serious breach of trust because he had lost that privilege to

access medical records upon leaving the Trust. Further, the Tribunal could not be satisfied there would be any reason for him to access Patient A records via hospital access at 4.26am on the morning of 20 March 2022.

56. Dr Ramadan concedes that it was not appropriate for him to have accessed Patient A's records in the circumstances. He stated:

> *"…on reflection, I do entirely accept that it was inappropriate to have accessed Patient A's records on 20 March in any event, as by then I had entered into an improper relationship with her and, therefore, I should no longer have had any involvement in her care."*

57. The Tribunal considered that, as this occurred after Dr Ramadan had formed a sexual relationship with Patient A, he should not have, in any medical capacity, looked at her medical records on that date.

> 24 March 2022

58. Dr Ramadan does not recall why he accessed Patient A's records on 24 March 2022 however he put forward a possible explanation of referring to her notes for educational purposes when discussing her case with his supervisor. He sets out in his statement:

> *"Furthermore, whilst I cannot now actively recall why I accessed Patient A's records at that time, I would only have done so for clinical reasons, i.e. as part of my role as a GP Registrar/trainee, such as reviewing her blood test results; and I certainly did not do so for any personal reasons or for any inappropriate purpose (such as to further my relationship with Patient A)."*
>
> …
>
> *I had a Case Based Discussion (CBD) about my consultation with Patient A with my Educational Supervisor,* [Dr I]*, subsequently on 30 March 2022; and, therefore, I may have been accessing her records in preparation for that discussion."*

59. In absence of any evidence to verify that his access on that date was for educational purposes, the Tribunal could not be satisfied that Dr Ramadan had in fact accessed Patient A's records to later discuss these with his educational supervisor.

60. The Tribunal also considered the audit records which showed that Dr Ramadan accessed these records three times that day. Whether or not this was for educational purposes, the Tribunal was satisfied that a sexual relationship between Dr Ramadan and Patient A had commenced by this time. It also bore in mind Dr G's opinion that:

> *'to access information is in itself an exercise of professional status and power. In my opinion, this consideration would outweigh any clinical or educational reason that Dr Ramadan might have for accessing Patient A's record'.*

61. Thus, it mattered not whether Dr Ramadan accessed Patient A's records for educational purposes, it is clear he was not permitted to do so as he had formed a relationship with Patient A by this time.

25 April 2022

62. In relation to 25 April 2022, Dr Ramadan states that the relationship with Patient A had ended by that date, and he had returned to Egypt. By this time Patient A had been to see another GP (on 13th April 2022) when she raised her relationship with Dr Ramadan to them. At this point, Dr Ramadan was no longer her GP, and he was aware of this. It noted however Dr G's observations:

> *'Dr Ramadan's sexual and/or improper relationship with Patient A had just ended. However, some sort of relationship still persisted between them as they had been in contact.'*

63. Dr Ramadan accepts that once he became aware of the complaint made against him on 25 April 2022, he accessed Patient A records to check whether a complaint had been made. This was further compounded by the fact that Dr Ramadan knew that he had done something wrong. In any event, he was not permitted to access Patient A records via his hospital access.

64. The Tribunal also had regard to the GMC guidance *Confidentiality: good practice in handling patient information (*April 2017) in which is sets out:

> *"The GDPR is based around six data protection principles and provides a range of rights for individuals. The principles state that personal data must:*

'…

- *be processed for specified, explicit and legitimate purposes and not in any manner incompatible with those purposes…'*

65. The Tribunal was of the view that by accessing the records on 25 April 2022, Dr Ramadan sought to determine the status of the complaint made against him by Patient A. He did not therefore access these for a legitimate purpose.

66. It was accepted by Dr Ramadan that the sexual relationship with Patient A was established by the time he had accessed her hospital records. There are references to Dr Ramadan seeking to amend Patient A's notes, but it is not clear which notes were being amended, and it is stated that no amendments were saved.

67. The Tribunal accepted Dr G's opinion, that as there was a sexual relationship underway between Dr Ramadan and Patient A, there was no valid reason for Dr Ramadan to be accessing Patient A's medical records or proceeding in her treatment as her doctor. The Tribunal accepted that accessing Patient A's records on these three occasions was the seriously below the standard expected of doctors and therefore this amounted to serious misconduct.

68. The Tribunal determined that all of the admitted paragraphs of the Allegation constituted misconduct which was serious. Dr Ramadan's actions in pursuing a vulnerable patient and entering into a relationship with her breached core professional obligations, while his subsequent attempts to delete the messages between them and access her records to remain informed on the state of her complaint against him demonstrated that he prioritised his own interests more than the welfare of Patient A.

69. The Tribunal concluded that while Dr Ramadan's may have been stressed, both personally and professionally, his conduct was particularly concerning, as it demonstrated a pattern of decision-making outside of GMP. The Tribunal emphasised that behaviour of this nature undermines public trust in the profession and warranted a finding of serious professional misconduct in respect of each of the paragraphs of the Allegation.

Impairment

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

71. The Tribunal considered factors set out in paragraph 76 of the judgment in the case of CHRE v NMC & Paula Grant [2011] EWHC 927 (Admin) and considered that limbs (a), (b) and (c) are engaged. It noted submissions of the GMC in relation to Dr Ramadan's integrity stating limb (d) was also engaged on the basis of his moral principles being called into question. Whilst Tribunal acknowledged that Dr Ramadan's actions did cast a shadow on his integrity as a doctor, in so far as he sought to delete messages exchanged with Patient A and accessed her records to find out about the complaint, it is not considered that this strictly engaged limb (d).

72. The Tribunal then considered the approach taken in *Cohen*. In determining whether a finding of current impairment of fitness to practise is necessary, the Tribunal looked for evidence of remediation and insight, and the likelihood of repetition, balanced against the three elements of the overarching statutory objective.

73. The Tribunal acknowledged that Dr Ramadan made full admissions regarding his misconduct on 29 January 2025.

74. The Tribunal gave careful consideration to Dr Ramadan's description of the circumstances at the time of the misconduct, mainly that he had considerable personal and domestic pressures and stresses. These included matters relating to XXX, difficulties he had in adjusting to life in the UK, stresses at work, feeling lonely and XXX. This resulted in Dr Ramadan XXX. Dr Ramadan explained that the time, he was XXX and did not want to be alone. XXX. However, Dr Ramadan stated in his oral evidence that despite these stresses, his judgment was not impacted at that time.

75. Dr Ramadan provided detailed reflections and gave evidence as to his current circumstances and how they are very different now. He stated that he is not afraid of speaking about XXX anymore, and although stress still effects how he engages with XXX. He stated he is more open now with friends and has more support around him. XXX. He stated he no longer sees XXX as a weakness and he has now XXX.

76. The Tribunal took into account XXX. The Tribunal acknowledged XXX may have contributed to his misconduct but to what extent was difficult to quantify. The Tribunal considered that XXX could impact his future risk of repetition.

77. XXX

78. XXX

79. The Tribunal was concerned that Dr Ramadan's actions presented a risk to patient safety and that his integrity could not be fully relied upon. In particular, his decision to delete Facebook messages relating to his relationship with Patient A—though not deemed dishonest—was seen as a significant lapse in professional integrity. His sole motive in doing so appeared to be self-preservation, as he sought to determine whether a complaint had been lodged against him. This conduct, as outlined in the case of *Grant,* cast doubt on his professional judgment. Additionally, the Tribunal found that he had prioritised protecting himself rather than prioritising Patient A's welfare, who he knew was vulnerable, further undermining confidence in his professionalism.

80. The GMC accepted that Dr Ramadan had demonstrated considerable insight into his misconduct and had engaged in remediation efforts, including completing the professional boundaries courses. However, the Tribunal noted gaps between these courses, raising questions about the consistency of his efforts.

81. While Dr Ramadan now seems to have more insight into his wrongdoing and has taken some steps towards remediation, the Tribunal questioned whether his actions have been fully remediated. Given XXX that Dr Ramadan's actions would not have occurred but for XXX, the Tribunal concluded that the conduct has not yet been remediated. XXX.

82. The Tribunal was of the view that XXX may well be a factor in this case and managed properly, it could possibly reduce the risk of repetition. However, his intermittent engagement with XXX was concerning. XXX. Dr Ramadan did not engage with XXX until he was prompted to do so XXX rather than using his own initiative. XXX, the Tribunal considered that Dr Ramadan had not been as proactive as expected since the proceedings began, only XXX two days before the hearing. Although he had taken preliminary steps—XXX —there was no evidence that he had commenced XXX as had been suggested to him.

83. The Tribunal considered that of particular concern was his patchy engagement with XXX, with a tendency to disengage during periods of high stress. Given that stressors are inevitable in medical practice, the Tribunal was not satisfied that Dr Ramadan currently had the necessary coping mechanisms to prevent future lapses in judgment. XXX. For these reasons, the Tribunal concluded that the risk of repetition remained high.

84. The Tribunal considered Mr Mellor's submissions and accepted that Dr Ramadan appears to be a good doctor, and that this was an isolated episode in an otherwise unblemished career. Nonetheless, the seriousness of the conduct was such that well-informed members of the public may have concerns about being treated by Dr Ramadan.

85. The Tribunal acknowledged that XXX could be linked to his misconduct and that he has taken some steps towards remediation. However, since this had not yet been fully addressed, the Tribunal could not be assured that similar misconduct would not occur in the future. The Tribunal determined that with XXX coupled with his inconsistent engagement with XXX, his fitness to practise is currently impaired due to the ongoing risk he poses to the public.

86. Applying the principles set out in *Yeong*, the Tribunal considered the seriousness of the misconduct, which involved a gross breach of trust. Even with the considerable insight and remediation presented, and the possible impact of XXX upon his actions, the Tribunal concluded that the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in this case.

87. The Tribunal further determined that the public expects doctors' conduct to justify its trust in them and expects doctors to maintain respectful relationships with colleagues and treat them fairly. Where doctors fail to do so in a significant way, as Dr Ramadan did in this case, the public's trust in the profession is undermined and a finding of impairment of fitness to practise is required. The Tribunal accepted that public confidence in the profession, and proper standards of professional conduct, would be damaged if a finding of impairment were not made in this case.

88. Therefore, the Tribunal determined that Dr Ramadan's fitness to practise is currently impaired by reason of misconduct.

Determination on Sanction - 12/05/2025

89. This determination will be read in private. However, as this case concerns Dr Ramadan's misconduct, a redacted version will be published at the close of the hearing.

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

The Evidence

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

Submissions

On behalf of the GMC

92. Ms Fordham submitted that Dr Ramadan's misconduct constitutes sexual exploitation of a vulnerable patient and warrants erasure. She stated that his actions represented such a serious departure from GMP and that the misconduct was difficult to remediate, justifying removal from the register in order to protect public confidence in the profession. She stated that the Tribunal must take into account proportionality, weighing the interest of the doctor against those of the public but must prioritise public safety, as the overarching objective demands. Ms Fordham submitted that patients must trust doctors not to misuse intimate disclosures, yet Dr Ramadan exploited Patient A's vulnerabilities, harming her mental health and undermining broader trust in the profession.

93. Ms Fordham submitted that Dr Ramadan abused his position by contacting Patient A on Facebook shortly after the consultation, where she disclosed anxiety, XXX, and social isolation. Within hours, their exchanges turned sexual, culminating in a visit to her home that evening and Dr Ramadan having sex with Patient A. This predatory behaviour, compounded by Patient A's vulnerability and social isolation, demonstrates a blatant disregard for professional boundaries and a disregard for her health, safety and wellbeing. His deletion of incriminating messages, Ms Fordham suggested, further shows a prioritisation of self-interest over patient welfare.

94. Ms Fordham contended that, despite attending Professional Boundaries courses, Dr Ramadan's remediation was delayed (June 2024, two years after the misconduct), undermining claims of timely insight. She submitted that XXX are not relevant when considering the effect his actions would have had on Patient A and the impact on public confidence in the profession. Critically, he failed to XXX. He did not engage with XXX until March 2025, raising concerns about future risk-taking. Ms Fordham stated that Dr Ramadan's inconsistent engagement with XXX. Ms Fordham directed the Tribunal to its own determination on impairment where it determined that XXX could heighten risks of his misconduct recurring.

95. Ms Fordham submitted that this case's severity is amplified by aggravating factors: abuse of trust, exploitation of a vulnerable patient, predatory behaviour, and sexual misconduct. She added that the testimonials highlighting Dr Ramadan's clinical competence are irrelevant; his colleagues confirmed that he had social support but he chose not to seek help. She submitted that his narrative of seeking "friendship" is contradicted by the rapid sexual escalation of interactions, suggesting that his explanation was false.

96. Ms Fordham submitted that erasure is the only proportionate sanction in this case. Suspension would be inappropriate as the misconduct is fundamentally incompatible with continued registration. She referred the Tribunal to the SG which emphasises erasure for abuse of trust involving vulnerable patients, specifically paragraphs 108 and 148. Ms Fordham submitted that Dr Ramadan's belated remorse and remediation courses cannot offset the gravity of his actions, which risk lasting damage to public confidence. His XXX further suggests unresolved risks. Ms Fordham stated that Dr Ramadan's predatory actions, prolonged deceit, and failure to safeguard a vulnerable patient irreparably damaged trust. Permitting his return to practise would signal tolerance for such breaches, harming the profession's reputation. She submitted the Tribunal must act decisively to uphold professional standards and public confidence.

<u>On behalf of Dr Ramadan</u>

97. Mr Mellor acknowledged the gravity of Dr Ramadan's misconduct, particularly concerning his relationship with Patient A. He submitted that Dr Ramadan fully accepts that his actions breached fundamental professional tenets, damaged public trust, and violated key principles outlined in CHRE v NMC and Grant (2011). Mr Mellor recognised the aggravating factors, including the abuse of his professional position, the vulnerability of Patient A, and the predatory nature of his conduct (initiating contact via Facebook). Mr Mellor conceded that

cases of this nature often warrant severe sanctions, including erasure, but he argued that the unique circumstances of this case justify a different outcome.

98. Despite the admitted seriousness of the misconduct, Mr Mellor highlighted significant mitigating factors: Dr Ramadan has demonstrated substantial insight and remediation: he admitted the Allegation early, apologised for his actions, and acknowledged the harm caused. He has undertaken targeted CPD courses (including professional boundaries and safeguarding training) and is developing a remediation plan. While the Tribunal noted gaps in his engagement with XXX, Mr Mellor emphasised that this was attributable to XXX which impacted on XXX. Mr Mellor added that Dr Ramadan has since XXX, which would reduce future risk of repetition. XXX.

99. Mr Mellor submitted that Dr Ramadan's otherwise unblemished career and positive testimonials from colleagues attest to his professional competence and good character. The misconduct was described as an isolated incident and, critically, XXX his actions were likely to have been influenced by XXX, which clouded his judgment XXX. While Dr Ramadan knew his actions were wrong, his ability to fully process their seriousness and effect was impaired. Mr Mellor distinguished this case from XXX, arguing that the XXX evidence as to XXX provides a mitigating explanation rather than an excuse.

100. Mr Mellor submitted that suspension, rather than erasure, is the proportionate response. He referenced the SG, noting that suspension is suitable where misconduct is serious but not fundamentally incompatible with continued registration. He submitted that due to Dr Ramadan's acknowledgment of fault and steps towards remediation, XXX, with evidence that future risk can be managed, no evidence of repeated misconduct since the incident, and with the likelihood that, following treatment, he can return to safe practice under supervision, that public confidence can be maintained through suspension, which serves as a deterrent while allowing for rehabilitation.

101. While acknowledging that erasure is often appropriate in cases involving sexual misconduct with vulnerable patients, Mr Mellor contended that it would be excessive here. He submitted that the XXX evidence indicated that Dr Ramadan's actions were substantially influenced by XXX, which is now being addressed. Erasure is reserved for cases where no other sanction can protect the public or uphold professional standards, whereas Dr Ramadan's case allows for remediation. Mr Mellor submitted that a well-informed member of the public would understand why erasure is not necessary given the mitigating circumstances.

102. Mr Mellor submitted therefore that a period of suspension with a review hearing is the most appropriate and proportionate sanction. The length of suspension is left to the Tribunal's discretion, though it is accepted that it may be of a considerable length due to the seriousness of the misconduct. The review hearing will allow the Tribunal to assess Dr Ramadan's progress XXX and remediation before any return to practise. Mr Mellor submitted that this approach would ensure public protection, maintain professional standards, whilst enabling Dr Ramadan to XXX.

The Tribunal's Approach

103. The decision as to the appropriate sanction to impose, if any, was a matter for the Tribunal exercising its own judgement. There was no burden or standard of proof at this stage. It recognised that every case will necessarily turn on its own facts.

104. In reaching its decision, the Tribunal had given careful consideration to the SG. It had borne in mind that the purpose of a sanction is not to be punitive although it may have a punitive effect.

105. The Tribunal had borne in mind that in deciding what sanction, if any, to impose, it should consider the sanctions available, starting with the least restrictive.

106. Throughout its deliberations, the Tribunal had taken into account the overarching objective, and applied the principle of proportionality, balancing Dr Ramadan's interests with the public interest.

107. When considering the principle of proportionality, the Tribunal had regard to the judgment in the case of *Bolton v. Law Society* [1994] 1 WLR 512, in which Sir Thomas Bingham stated that '*the reputation of the profession is more important than the fortunes of any one individual member…'*

108. The Tribunal has taken into account its earlier determinations on the facts and on impairment, the SG and GMP, the submissions of Ms Fordham, on behalf of the GMC, and the submissions of Mr Mellor on behalf of Dr Ramadan.

The Tribunal's Determination on Sanction

109. The Tribunal first considered and balanced the aggravating and mitigating factors in this case.

Aggravating factors

110. The Tribunal first considered the aggravating factors. It considered the following paragraphs of the SG to be relevant:

> *'**55** Aggravating factors that are likely to lead the tribunal to consider taking more serious action include:*
> *…*
> ***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)*

111. In relation to abuse of professional position, vulnerable patients, and predatory behaviour, the Tribunal had sight of the following paragraphs of the SG;

> ***142** Trust is the foundation of the doctor-patient partnership. Doctors' duties are set out in paragraph 53 of Good medical practice and in the explanatory guidance documents Maintaining a professional boundary between you and your patient and Ending your professional relationship with a patient*
>
> ***143** Doctors must not use their professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.*
>
> ***145** Where a patient is particularly vulnerable, there is an even greater duty on the doctor to safeguard the patient. Some patients are likely to be more vulnerable than others because of certain characteristics or circumstances, such as:*
>
> ***a** presence of mental health issues*
> *…*
> ***e** history of abuse or neglect.*

146 Using their professional position to pursue a sexual or improper emotional relationship with a vulnerable patient is an aggravating factor that increases the gravity of the concern and is likely to require more serious action against a doctor.

147 If a doctor has demonstrated predatory behaviour, motivated by a desire to establish a sexual or inappropriate emotional relationship with a patient, there is a significant risk to patient safety, and to public confidence and/or trust in doctors. More serious action is likely to be appropriate where there is evidence of (this list is not exhaustive):
a inappropriate use of social networking sites to approach a patient outside the doctor-patient relationship
…
c visiting a patient's home without any appointment or valid medical reason

148 More serious action, such as erasure, is likely to be appropriate where a doctor has abused their professional position and their conduct involves predatory behaviour or a vulnerable patient, or constitutes a criminal offence.

150 Sexual misconduct seriously undermines public trust in the profession. The misconduct is particularly serious where there is an abuse of the special position of trust a doctor occupies, or where a doctor has been required to register as a sex offender. More serious action, such as erasure, is likely to be appropriate in such cases.'

112. The Tribunal first took account of the seriousness of the Allegation in the case, given Patient A's vulnerabilities. Patient A trusted Dr Ramadan as her doctor and opened up to him about her health concerns and vulnerabilities and he abused her trust by using this information to pursue her and enter into a sexual relationship. The Tribunal found that Dr Ramadan's intention from the onset was to have sex with her and not to simply befriend her on Facebook as he had made out. Soon after, he attended her home without any justifiable medical reason but rather a personal desire to engage in sex with her.

113. Patient A also had a history of alcohol abuse. Dr Ramadan had himself recorded these vulnerabilities during his consultation with her. In his witness statement, he stated XXX

114. Dr Ramadan, as he previously accepted, was fully aware that Patient A was vulnerable by virtue of her mental health and her history of alcohol abuse. The Tribunal concluded that these aspects made Patient A even more vulnerable.

115. Dr Ramadan used his professional position, to pursue and maintain a sexual relationship with Patient A for approximately four weeks. The Tribunal formed the view Dr Ramadan acted on Patient A's disclosure of her sexual inclinations and concluded that this constituted serious predatory behaviour against a particularly vulnerable patient. Dr Ramadan further breached Patient A's trust by inappropriately accessing her GP and hospital records when he was not permitted to do so.

Mitigating Factors

116. The Tribunal then went on to consider the mitigating factors. It considered the following paragraphs of the SG:

> *'**24** The tribunal needs to consider and balance any mitigating factors presented by the doctor against the central aim of sanctions (see paragraphs 14–16). The tribunal is less able to take mitigating factors into account when the concern is about patient safety, or is of a more serious nature, than if the concern is about public confidence in the profession.*
>
> ***25** The following are examples of mitigating factors.*
>
> ***a** Evidence that the doctor understands the problem and has insight, and of their attempts to address or remediate it. This could include the doctor admitting facts relating to the case, apologising to the patient (see paragraphs 42–44), making efforts to prevent behaviour recurring, or correcting deficiencies in performance or knowledge of English.*
>
> ***b** Evidence that the doctor is adhering to important principles of good practice (ie keeping up to date, working within their area of competence), and of the doctor's character and previous history. This could include evidence that the doctor has not previously been found to have impaired fitness to practise by a tribunal, a previous MPTS panel or by the GMC's previous panels or committees.*

c Circumstances leading up to any incidents that raise concern – eg inexperience (see paragraphs 27–30) or a lack of training and supervision at work.

d Personal and professional matters, such as work-related stress.

e Lapse of time since an incident occurred.'

117. The Tribunal acknowledged that Dr Ramadan has no previous fitness to practise history and is of previous good character, against the background of a nine year career. The Tribunal also took into account Dr Ramadan's admissions at the outset of these proceedings.

118. The Tribunal further bore in mind that Dr Ramadan has acknowledged his misconduct, acknowledged that this constituted a breach of trust, apologised for his behaviour and there has been no repetition of his misconduct, albeit he has not worked since 2022. However, the Tribunal had been presented with no evidence that Dr Ramadan had apologised directly to Patient A since the incident.

119. The Tribunal took into account that three years have elapsed since the incident, and it did appear that this was isolated, with no evidence of anything similar occurring prior or since this allegation. However, the Tribunal also noted that Dr Ramadan has not been working since the time of the events and is currently residing in Egypt.

120. The Tribunal had received positive testimonial evidence about Dr Ramadan from various clinicians based on his time at Kettering General Hospital. The Tribunal noted that Dr Ramadan is a man of good character and has had no clinical issues as a doctor. It bore in mind the testimonial evidence which described Dr Ramadan as a '*valuable asset to the NHS'* who is *'skilled, respectful and a dependable doctor who consistently priortisised patient welfare…*'. The Tribunal apportioned some weight to these testimonials however bore in mind the serious nature of the conduct in this case and that it related directly to the welfare of a vulnerable patient.

121. The Tribunal noted that Dr Ramadan has taken some steps to remediate and has provided a reflective statement following targeted CPD including the Maintaining Professional Boundaries and the subsequent refresher course. The Tribunal considered there were significant gaps between the courses, which were undertaken in May 2022, August

2022, June 2024 and then March 2025 and acknowledged this may be partially attributable to XXX impacting on his ability to prepare for the hearing.

122. The Tribunal was satisfied that Dr Ramadan has some insight in relation to his misconduct which is contained in his witness statement, reflection and was alluded to in his oral evidence to the Tribunal. He understands the gravity of his conduct and the serious impact this had on Patient A, his GP Practice, the Trust and on public confidence in the profession as a whole.

123. However, XXX, and the Tribunal's finding on impairment, insight remains partial owing to XXX, both at the time of his actions and at present. XXX.

124. XXX. The Tribunal determined that for this reason Dr Ramadan's insight remains incomplete.

125. The Tribunal acknowledged the circumstances surrounding XXX to be a mitigating factor. It took into account that, at the time of the events, Dr Ramadan was dealing with significant personal and professional stressors in his life and was experiencing XXX during that time. The Tribunal considered this to be relevant context for his behaviour however weighed this against the serious nature of the misconduct.

126. XXX

127. XXX

128. XXX

129. XXX

130. The Tribunal balanced the aggravating and mitigating factors throughout its deliberations and went on to consider each sanction in order of ascending severity, starting with the least restrictive.

No Action

131. The Tribunal first considered whether to conclude the case by taking no action.

132. The Tribunal determined that to take no action would be inappropriate. The Tribunal did not consider that there were any exceptional circumstances that would justify such a course. It would not be sufficient, proportionate or in the public interest to conclude the case by taking no action.

Undertakings

133. The Tribunal noted that no undertakings had been agreed in this case.

Conditions

134. The Tribunal next considered whether it would be appropriate to impose conditions on Dr Ramadan's registration. It bore in mind that any conditions imposed should be appropriate, proportionate, workable and measurable.

135. The Tribunal noted that conditions were not put forward by either party and determined that the imposition of conditions on Dr Ramadan's registration would be unworkable given XXX.

136. The Tribunal further considered that the imposition of conditions on Dr Ramadan's registration would be inappropriate as it would not send a sufficiently robust message to the public or the profession as to the inappropriateness and seriousness of his misconduct. In the circumstances, the Tribunal determined that a period of conditional registration would not meet the public interest.

Suspension

137. The Tribunal then went on to consider whether imposing a period of suspension on Dr Ramadan's registration would be appropriate and proportionate.

138. The Tribunal had regards to paragraphs 91, 92, 93, 97(a),(e),(f) and (g) of the of the SG which indicate circumstances in which it may be appropriate to impose a sanction of suspension. These provide:

> *'**91** Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor*

from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.

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

93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions (see paragraphs 24–49).
…
97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.

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

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

f No evidence of repetition of similar behaviour since incident.

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

139. The Tribunal had regard to its findings that Dr Ramadan had breached paragraphs 27, 53, and 65 of GMP 2013.

140. The Tribunal bore in mind that this was a serious case involving a vulnerable patient who was living alone. She made her vulnerabilities clear to Dr Ramadan during the consultation he had with her. Dr Ramadan had a greater duty to safeguard Patient A however instead used his position as a doctor to pursue her for sex which the Tribunal determined amounted to a gross abuse of trust and predatory behaviour. A sexual relationship commenced within eight hours of the initial contact made by Dr Ramadan via social media and continued for approximately a month.

141. In relation to Dr Ramadan's remediation, the Tribunal accepted that he had carried out some work by virtue of completing the CPD courses and had some insight as to his misconduct. However, in relation to XXX, the Tribunal remained of the view, that there was much work to be done for Dr Ramadan to sufficiently address and improve XXX such that it does not allow him to act this way again. In view of the limited steps he had taken thus far to address XXX, the Tribunal determined that the risk of repetition remains high. As such, Dr Ramadan's behaviour, in view of XXX still posed a risk to patient safety.

142. The Tribunal took account XXX that Dr Ramadan's judgement as to the effects of his conduct on himself and Patient A was XXX however, noted that this was not XXX that he would not know that his actions were wrong and breached GMP. It therefore concluded that Dr Ramadan was fully aware at the time, that he was breaching the fundamental tenets of the profession. The Tribunal found that XXX, whilst relevant to the conduct, could not sufficiently displace the greater duty he was obliged to discharge in relation to Patient A's care. The Tribunal therefore concluded that, contrary to the submissions made by Mr Mellor, XXX could not sufficiently mitigate against the seriousness of the conduct which would undermine the need to maintain professional standards and maintain confidence of the public if not marked with a more serious sanction.

143. The Tribunal was of the view that if the public knew that a doctor who was trusted by a highly vulnerable patient as her GP, was preying on the very vulnerabilities he was sought to assist her with and then went on to pursue her for sex, this would profoundly damage the public's trust and confidence in the profession. The Tribunal also considered that the public, knowing that despite XXX, he knew what he was doing was wrong, would be appalled if Dr Ramadan was allowed to remain on the medical register. The Tribunal determined that if Dr Ramadan fully engaged with XXX in time this may address the public safety element of the overarching objective. However the Tribunal could not be sure of this based on Dr Ramadan's tendency to disengage when stress levels are high. However, the nature of the misconduct

remained so serious that limbs (b) and (c) of the overarching objective would nevertheless remain engaged.

144. In these circumstances, the Tribunal did not consider that a suspension order, even with a review was an appropriate or proportionate sanction.

Erasure

145. The Tribunal considered the following paragraphs of the SG:

> *'**107** The tribunal may erase a doctor from the medical register in any case – except one that relates solely to the doctor's health and/or knowledge of English – where this is the only means of protecting the public*
>
> ***108** Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor*
>
> ***109** Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).*
>
> ***a** A particularly serious departure from the principles set out in Good medical practice where the behaviour is difficult to remediate*
>
> ***b** A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety*
> …
> ***d** Abuse of position/trust (see Good medical practice, paragraph* [65]*: 'You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession')*
> …
> ***i** Putting their own interests before those of their patients (see Good medical practice introduction on page 7 'Patients must be able to trust medical professionals with their lives and health. To justify that trust you must make the care of patients your first*

concern, and meet the standards expected of you in all four domains.' and paragraphs 94–97 regarding conflicts of interest).'

146. The Tribunal balanced the impact of XXX with the severity of his misconduct. The Tribunal considered that, regardless of XXX, Dr Ramadan knew before beginning a relationship with Patient A that what he was doing was wrong. It formed the view that not appreciating the effects of his actions on Patient A did not change the fact that he knew his actions (which would give rise to those effects) were wrong. His targeting of a highly vulnerable patient who came to him for help and advice about her mental health and sexual behaviour amounted to a serious departure from the principles set out in GMP. Dr Ramadan was aware of GMP prohibiting him from pursuing a sexual relationship with a patient and further accepted that he was aware of similar restrictions imposed on doctors practising in Egypt. The Tribunal concluded that Dr Ramadan knowingly used his position of trust to assuage his own needs to the detriment of Patient A's welfare and this was at odds with the fundamental tenets of the profession.

147. In light of the SG and for all the above reasons, the Tribunal determined that the only appropriate and proportionate sanction in this case was that of erasure. It concluded that any lesser sanction would fail to uphold the overarching objective given its finding at the impairment stage. It determined that erasure was the only appropriate and proportionate sanction to maintain public confidence in the medical profession, and to uphold proper professional standards and conduct for members of the profession.

148. The Tribunal therefore directs that Dr Ramadan's name be erased from the Medical Register.

Determination on Immediate Order - 12/05/2025

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

Submissions

On behalf of the GMC

150. Ms Fordham referred the Tribunal to paragraphs 172 and 173 of the SG.

151. Ms Fordham submitted that the imposition of an immediate order upon Dr Ramadan's registration was required based the Tribunal findings in relation to sanction.

152. Ms Fordham submitted that, given the Tribunal's findings at the sanction stage, the imposition of an immediate order was necessary in respect of risk to patient safety and the wider public interest, and the confidence in the profession.

On behalf of Dr Ramadan

153. Mr Mellor advised the Tribunal that he had not been instructed at this stage and therefore did not make any submissions relating to the imposition of an immediate order.

The Tribunal's Determination

154. In reaching its decision, the Tribunal has exercised its own judgement, and has taken account of the principle of proportionality. The Tribunal has borne in mind that it may impose an immediate order where it is satisfied that it is necessary for the protection of members of the public, is in the public interest, or is in the best interests of the practitioner.

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

> *'172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order*

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

156. The Tribunal considered that, due to the serious nature of Dr Ramadan's misconduct, an immediate order was both necessary and proportionate.

157. It considered that, given the risk of repetition, an immediate order was necessary to protect the public, to uphold proper professional standards and conduct for members of the profession and to maintain public confidence in the profession. Further, the Tribunal concluded that public confidence in the profession would be undermined if an immediate order was not imposed given the nature of Dr Ramadan's misconduct.

158. Accordingly, the Tribunal determined to impose an immediate order upon Dr Ramadan's registration.

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

160. The interim order is hereby revoked.

161. That concludes this case.

ANNEX A – 13/02/2025

Application to Adjourn under Rule 29(2) of the Rules and Vary existing Interim Order under the Medical Act 1983

1. This determination will be handed down in private under the provisions of Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). However, as this case concerns Dr Ramadan's alleged misconduct a redacted version could be published at the close of the hearing.

2. The GMC has applied for an adjournment of the hearing XXX.

3. XXX

4. XXX

5. XXX

6. XXX

7. Mr Mellor, on behalf of the Dr Ramadan, did not object to the GMC application to adjourn the hearing and acknowledged XXX. However, Mr Mellor requested that the matter be expedited as much as could be.

8. XXX

9. The Tribunal also considered that any party not bringing current matters to the attention of the parties at the case management stage is relevant. However, it considered that this must be balanced with fairness to the parties.

10. In the circumstances the Tribunal determined that, XXX, it was in the interests of fairness to allow the GMC time XXX.

11. The Tribunal therefore adjourned the matter part-heard, subject to Rule 29(2) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules') to conclude matters in this case.

Application on Interim Order

12. The Tribunal invited submissions as to any interim order that may be in place.

Submissions

Submissions on behalf of the GMC

13. Ms Fordham notified the Tribunal that Dr Ramadan currently has an interim order of conditions in place which is due to expire on 18 April 2025 and went on to make an application to replace this order with an interim order of suspension in accordance with section 41A (3) of the Medical Act 1983. This was made primarily on the basis of Dr Ramadan's formal admission of the Allegation in its entirety and the matters now being found proved.

14. Ms Fordham submitted that given the findings of fact made by this Tribunal, it was necessary, appropriate, and proportionate to replace the current interim order of conditions with one of suspension. She submitted that an order of conditions was no longer appropriate, proportionate, or sufficient in the circumstances of this case and failed to reflect the seriousness of the allegation. She drew the Tribunal's attention to the MPTS Guidance document *'Imposing interim orders Guidance for the interim orders tribunal, tribunal chair and the medical practitioners tribunal'* (IOT Guidance) (February 2024), and that this is a case where a finding of the doctor's sexual pursuit of a vulnerable patient had been made. Further, the doctor knew that the patient was vulnerable. She submitted that there was a significant risk to the public as well as public confidence in the profession, in that the public would be *'outraged'* and confidence in the profession would be damaged if Dr Ramadan were allowed to continue to practise given those findings, either with a chaperone or XXX. She submitted that Dr Ramadan had acted outside the perimeters where a chaperone would be available, namely outside of working hours, online and accessing records in the early hours of the morning via a mobile app.

15. She drew differences between the considerations of the IOT which were to assess whether there may be impairment of the doctor's fitness to practise which poses a real risk to members of the public. She submitted that the Tribunal, having found matters proved, could consider impairment on that basis.

16. Ms Fordham submitted that Dr Ramadan's actions constituted a pattern of sexually inappropriate conduct over a period of time and the guidance referring to '*patients'* could be interpreted to include a single patient, who was vulnerable.

17. Ms Fordham concluded by submitting that, if the Tribunal determined not to impose an interim order of suspension upon Dr Ramadan's registration, it should, in the alternative, vary the current conditions imposed on the doctor's registration to include specific conditions requiring the doctor to XXX, and provide further information relating to XXX to the GMC.

Submissions on behalf of Dr Ramadan

18. Mr Mellor submitted that an interim order of suspension was neither necessary nor proportionate in this case but accepted there was a need to vary the interim order of conditions currently imposed upon Dr Ramadan's registration.

19. Mr Mellor submitted that Dr Ramadan had admitted an inappropriate sexual relationship with Patient A and that the GMC had been aware of that admission prior to the last Interim Order Tribunal review, which took place on the 27 November 2024. He stated that the admissions had now led to a formal finding, but this had not changed the level of risk or the information in relation to risk. Mr Mellor submitted that suspension was neither necessary or proportionate to guard against the risk, either to patients or to the public.

20. Mr Mellor reminded the Tribunal of XXX.

21. Mr Mellor further submitted that Dr Ramadan has fully complied with the conditions currently in place under the interim order and the current conditions, including those requiring a chaperone, are effective.

22. Mr Mellor stated that guidance refers to patients and not a single patient and therefore the Tribunal should exercise caution when considering whether this is a pattern of behaviour or sexually inappropriate conduct towards Patient A only.

23. Mr Mellor acknowledged that the admitted facts of this case were serious, but an interim order of suspension would be disproportionate. He submitted that conditions can be workable and effective in cases relating to sexual misconduct and that Interim Orders Tribunals determined the chaperone conditions to be workable and effective.

24. Mr Mellor submitted that the further conditions proposed by the GMC would be proportionate and necessary and would suitably address XXX concerns.

The Tribunals decision

25. The Tribunal noted the Medical Act 1983, in particular the following:

'41A.— Interim Orders

(3) Where an interim suspension order or an order for interim conditional registration has been made in relation to any person under any provision of this section (including this subsection), [an Interim Orders Tribunal or a Medical Practitioners Tribunal] may, subject to subsection (4) below—

(a) revoke the order or revoke any condition imposed by the order;
(b) vary any condition imposed by the order;
(c) if satisfied that to do so is necessary for the protection of members of the public or is otherwise in the public interest, or is in the interests of the person concerned, replace an order for interim conditional registration with an interim suspension order having effect for the remainder of the term of the former;'

26. The Tribunal was thus satisfied that it could consider the application to vary, revoke or replace the current Interim Order of conditions. It then went on to consider the IOT Guidance, in particular the following:

'5. An IOT may make an order under one or more of three grounds:

i. when it considers it necessary to do so for the protection of members of the public

ii. when it is otherwise desirable in the public interest, to maintain public confidence and uphold proper standards of conduct and behaviour

iii. where it is in the interests of the doctor.'

'42. The following factors are likely to indicate, balanced alongside other considerations, that a case is likely to raise significant public confidence issues if no interim action is taken.

[…]

b. Allegations that a doctor exhibited predatory behaviour in seeking or establishing a sexual or improper emotional relationship with a patient or a former patient where, at the time of the professional relationship, the patient was particularly vulnerable.

c. Serious concerns about a doctor's sexualised behaviour towards a patient or a colleague in a single episode.

d. Allegations of a pattern of sexually motivated behaviour towards patients, their relatives or colleagues.'

27. The Tribunal bore in mind the following factors in the IOT Guidance which when balanced with other considerations, are likely to indicate that a case is likely to raise significant public confidence issues if no interim action is taken XXX

28. The Tribunal also bore in mind the factors contained within the IOT Guidance when considering whether an interim order of conditions or suspension would appropriate, namely:

'48. In deciding the appropriate action, the tribunal must very carefully consider the issue of proportionality in weighing the significance of any risk to patient and public safety or public confidence, for example in not suspending the doctor against the damage to them by preventing them from practising

49. The suspension of a doctor's registration on 'public protection' grounds can only be done if it is necessary but there is no such qualification on suspension where it is desirable in the 'public interest' to maintain public confidence

50. When considering the imposition of conditions, the IOT must ensure that any conditions imposed are workable, enforceable and will protect the public, the wider

public interest or the doctor's own interests. Conditions should normally follow the format of conditions set out in the Interim Conditions bank and should:

a. be adequately defined to minimise opportunities for misinterpretation;

b. be directed at the doctor and not at other parties;

c. be capable of being complied with by the doctor;

d. enable breaches to be readily identified.

52. Where allegations involve sexual misconduct, there may be a significant risk to patient safety as well as public confidence in the profession if decisions at the interim stage are not seen to reflect the seriousness of the individual case.

[…]

53. In cases involving allegations of sexual misconduct, one or more of the following factors are a strong indicator that conditions requiring the use of a chaperone may not be workable or effective.

[…]

e. Allegations that indicate a possible pattern of behaviour of a doctor engaging or seeking to engage in a sexual or an improper emotional relationship with more than one patient. Chaperone conditions may not be fully effective in protecting patients from this type of behaviour by doctors, since most contact of this nature is likely to occur in unchaperoned time, outside a consultation23. An IOT may, however, consider a chaperone condition to be proportionate in light of a single allegation depending on the circumstances of the case and having considered all the relevant factors set out in this guidance in reaching their decision.'

29. This is a case where Dr Ramadan established a sexual or improper emotional relationship with a patient, where at the time of the professional relationship, the patient was particularly vulnerable and therefore determined that an Interim Order was appropriate to protect the public and maintain public confidence.

30. In reaching its decision on the application to vary the order, the Tribunal took into account the principle of proportionality. It went onto consider if it was sufficient for the existing order of conditions to remain, or to be varied, or for the order to be replaced with an order of suspension. In its deliberations, it took into account the need to balance the public interest and that of the doctor in the light of the admitted facts of the case.

31. The Tribunal considered the current conditions and formed the view that these did not adequately address the serious nature of the allegations which had now been found proved. It determined that the current conditions do not address XXX. Therefore, the Tribunal determined that the current conditions would not adequately protect the public or the wider public interest.

32. The Tribunal then went on to consider the imposition of further proposed conditions and whether these would address the risk to the public, maintain public confidence and whether these are in the best interest of the doctor.

33. The Tribunal bore in mind that the admitted conduct took place over a period of time, outside normal consultation hours, via social media platforms, and sometimes late at night. Dr Ramadan had also visited the patient's home and had met her socially elsewhere. Further, the patient's records were accessed via the mobile app during the early hours of the morning. It did not consider that the chaperone conditions were adequately workable or effective. The Tribunal also considered whether a condition of close or direct supervision could be imposed however it concluded that this again would only address concerns at work and during working hours and would not adequately address the risk posed by the doctor in this case, as the sexual misconduct took place outside the working environment. It noted that the condition requiring Dr Ramadan to XXX. However, when weighing up the issue of proportionality and the significance of risk to patients' safety, the Tribunal concluded that such conditions would not adequately protect patients, including vulnerable patients, from risk of sexual misconduct, in view of the circumstances of this case.

34. The Tribunal bore in mind its primary duty is to protect members of the public and the wider public interest, and not to assume responsibility for, or give priority to, XXX.

35. The Tribunal was mindful of the submission made regarding Dr Ramadan having complied with conditions imposed by the previous IOT and he had no other fitness to practise history with the GMC. However, it did consider that this allegation, being one of sexual

misconduct, posed a significant risk to patient safety and public confidence in the profession if an interim order of suspension was not imposed, which it considered adequately reflected the seriousness of this case.

36. The Tribunal did form the view that this was a pattern of behaviour and interpreted reference in the IOT Guidance to patients to include a single patient, who was particularly vulnerable.

37. In view of Dr Ramadan's admissions to the entirety of the Allegation, and the Tribunal's consequent findings on the facts, particularly as these related to proven allegations of pursuing a sexual relationship with a vulnerable patient during non-working hours, it was satisfied that only an order of suspension was appropriate as this was necessary on the grounds of public protection.

38. Whilst the Tribunal noted that this interim order of suspension would restrict Dr Ramadan's ability to practise medicine, it is satisfied that the order imposed is the proportionate response. The serious nature of the Tribunal's findings is a material change in the circumstances of the case which warranted the replacement of the current order of conditions with one of suspension. The Tribunal was satisfied that the interim order of suspension now imposed serves to protect the health, safety, and well-being of the public, maintain public confidence in the profession and upholds proper professional standards and conduct.

39. The order will be reviewed before 18 April 2025.

40. Accordingly, the order will take effect from today. Notification of this decision will be served upon Dr Ramadan in accordance with the Medical Act 1983.

Schedule 1

17 March 2022
21 March 2022

Schedule 2

Mental health