PUBLIC RECORD

Dates: 20/07/2026 - 22/07/2026

Doctor:	Dr Stavros DIMITRIADIS
GMC reference number:	7826802
Primary medical qualification:	Ptychio Iatrikes 2008 Aristotle University of Thessaloniki

Type of case	Outcome on facts	Outcome on impairment
New – misconduct	Facts relevant to impairment found proved	Fitness to practise impaired

Summary of outcome

Suspension six months

Immediate order imposed

Review directed

Tribunal:

Legally Qualified Chair	Mr Neil Fielding
Lay Tribunal Member:	Mr Stephen Downing
Registrant Tribunal Member:	Dr Helen McCormack

Tribunal Clerk:	Ms Fiona Johnston

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Peter Lowdns, Counsel, instructed by MDU
GMC Representative:	Ms Chloe Fairley, Counsel

Attendance of Press / Public

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

Protecting the Public

Throughout the decision making process the tribunal has borne in mind the statutory duty as set out in s1(1) of the Medical Act 1983 (the 1983 Act) to protect the public. The tribunal has considered the relevance and impact on each of the three distinct parts of public protection to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Impairment - 21/07/2026

Background

1. Dr Dimitriadis obtained his primary medical qualification in Greece in 2008. He went on to complete an MSc in Gastroenterology in 2013. Dr Dimitriadis completed his specialist training in Germany and worked in Germany for over 10 years before moving to the UK in 2022. Between January 2023 and September 2024, he was employed as a Senior Clinical Fellow in Gastroenterology at University Hospital Coventry ('UHC'), which is where the events giving rise to these proceedings occurred.

2. It is alleged that Dr Dimitriadis behaved in a manner towards Miss A that was sexually motivated and was an abuse of his more senior position.

3. Ms A was a XXX working in the XXX Department at the same hospital, predominantly in the XXX rooms.

Events that led to the allegation

4. Ms A was a XXX at the UHC and worked alongside Dr Dimitriadis. Ms A described Dr Dimitriadis as appearing friendly and pleasant when he first joined the hospital. She stated that he was flirtatious with everyone. She recalled an occasion when Dr Dimitriadis told her that he had slept with every nurse at a previous hospital where he had worked. He explained that it had been a small department and that the nurses would talk about him. Ms A stated that Dr Dimitriadis would make comments of this nature either when they were alone or when he was with a group of female colleagues.

5. Ms A also recalled a conversation during which Dr Dimitriadis spoke about enjoying visiting sex museums and other venues where people could engage in sexual activity. He also told her about places in Greece where he had gone to have sex.

6. Ms A described an occasion when she and Dr Dimitriadis had been working together in a room within the XXX, alongside another doctor who had been Dr Dimitriadis's mentor. After they had finished the XXX and all of the patients had been seen, the senior doctor left the room. Ms A remained behind to clean up while Dr Dimitriadis was using the computer. As she began to leave the room, Dr Dimitriadis walked alongside her and put his arm around her shoulders. He then said to her, "I'm going to have sex with you before I go back to..." Ms A could not recall in her witness statement whether he had said Greece or Germany. She recalled that there had been no conversation either before or after Dr Dimitriadis made the comment. At the time, she laughed it off because they were still, in her words, on "friendly terms."

7. Ms A described an occasion, at least six months after Dr Dimitriadis had started working at the hospital, when he showed her what she described as indecent images and a video of himself.

8. On that occasion, Ms A was working on XXX, where there were two patients present. Dr Dimitriadis 's office was located nearby. Ms A was sitting at the XXX when Dr Dimitriadis approached and stood opposite her. They initially spoke about a tattoo on his shoulder, and he lifted the sleeve of his shirt to show it to her.

9. While standing at the nurses' station, Dr Dimitriadis placed his mobile phone on the desk with the screen facing upwards and began scrolling through the photo gallery. As he did so, Ms A saw an image on the screen of Dr Dimitriadis holding his erect penis. The image remained visible for a couple of seconds before he swiped to the next item, which was a video of Dr Dimitriadis engaging in anal sex.

10. Ms A stated that neither she nor Dr Dimitriadis said anything at the time. She recalled that Dr Dimitriadis appeared to be smirking and did not seem concerned that she could see what was displayed on the screen. She stated that there had been no sexual conversation leading up to the incident and that she had not asked to see any photographs or videos and she was shocked. They had simply been engaged in general conversation before he began scrolling through his phone.

The Outcome of Applications made during the Facts Stage

11. Ms Chloe Fairly, Counsel on behalf of the GMC made an application pursuant to Rule 35(4) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended

('the Rules') for the complainant Ms A be granted anonymity throughout these proceedings to protect their privacy as an alleged victim in sexually motivated allegations. Dr Peter Lownds on behalf of Dr Dimitriadis did not oppose the application.

12. The Legally Qualified Chair (LQC) drew the Tribunal's attention to relevant legal principles, and Rule 35(4) of the Rules which states:

> *"35(4) The Committee or Tribunal may, upon the application of a party, agree that the identity of a witness should not be revealed in public"*

13. The Tribunal accepted the submission made by the GMC. It determined that it was appropriate and in the interests of justice that Ms A be afforded anonymity throughout these proceedings in order to mitigate any further negative impact on the proceedings and to preserve their dignity. It determined that they should be referred to as Ms A during these proceedings.

The Allegation and the Doctor's Response

14. The Allegation made against Dr Dimitriadis is as follows:

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

1. Between 16 January 2023 and 30 September 2024 while working at University Hospital Coventry ('UHC') you told XXX Miss A that you:

    a. had slept with every nurse at a previous hospital you had worked in, or words to that effect; Admitted and found proved

    b. liked to go to sex places like sex museums and places you can go to have sex, or words to that effect. Admitted and found proved

2. In or around April – May 2023 at UHC you:

    a. placed your arm around XXX Miss A's shoulder; Admitted and found proved

    b. said to XXX Miss A 'I'm going to have sex with you before I go back to Greece/Germany' or words to that effect. Admitted and found proved

3. In around July 2023 at the XXX in UHC you placed your phone on the desk with the screen facing upwards causing XXX Miss A to see a:

    a. photograph of your erect penis; Admitted and found proved

    b. video of you engaging in anal sex. Admitted and found proved

4. Your actions as set out at paragraphs 1 - 3 were:

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

b. an abuse of your more senior position. **Admitted and found proved**

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

The Admitted Facts

15. At the outset of these proceedings, Dr Dimitriadis through his Counsel, Mr Peter Lownds, made admissions to the paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the 'the Rules'. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs of the Allegation as admitted and found proved.

The impairment stage

16. 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 Dimitriadis's fitness to practise is impaired by reason of his misconduct.

Witness Evidence

17. The Tribunal received witness statements on behalf of the GMC from:

- Miss A, XXX at UHC.

18. The Tribunal received witness statements on behalf of Dr Dimitriadis from:

- Ms B, Healthcare Assistant, at UHC;
- Ms C, Programme Administrator at UHC;
- Dr D, consultant gastroenterologist at UHC;
- Ms E, former colleague;
- Dr F, consultant gastroenterologist ay UHC.

19. Dr Dimitriadis provided a witness statement, dated 16 March 2026. He also gave oral evidence during these proceedings.

20. Dr Dimitriadis told the Tribunal that he sought psychological support at the time he was trying to understand what had happened and why the complaint had been made. XXX.

21. Dr Dimitriadis stated that he lives XXX in Greece XXX. He also stated that he now works full-time in private practice in Greece. When questioned about the power imbalance involved in hugging Ms A, Dr Dimitriadis stated that, at the time, he believed it was normal because

that is how people commonly greet each other in Greece. However, he now recognises that there was a significant power imbalance.

22. Dr Dimitriadis stated that when he read Ms A's statement provided to the GMC, he recognised feelings that he had not previously appreciated. He said he was shocked to learn that his misconduct and behaviour had caused her to feel fearful, reluctant to attend work, and distressed. He stated that this was something new for him to understand and that he deeply regrets causing her to feel that way. He said that it was never his intention to cause such distress.

23. Dr Dimitriadis stated that he now accepts that his sexualised banter was perceived as sexually motivated conduct and that it breached Good Medical Practice. He also accepted that the images and videos on his phone referred to in Allegation 3a and 3b were sexually explicit and inappropriate. He stated that the public expects doctors to behave professionally and accepted that, by showing explicit sexual images and videos, his behaviour damaged public trust and confidence in the medical profession. He added that he believes public confidence can be maintained where a doctor demonstrates remediation and insight, which he stated he is currently seeking to demonstrate.

24. Dr Dimitriadis stated that he has undertaken courses on professional boundaries, bullying and harassment, social media, and that the professional boundaries course also addressed sexual misconduct.

25. Dr Dimitriadis stated that the professional boundaries course was delivered on a one-to-one basis. He said he completed exercises, discussed various scenarios with the facilitator, undertook preparatory work beforehand, and was provided with reading materials. He explained that the course covered a range of professional boundary issues but was primarily focused on his own circumstances.

26. Dr Dimitriadis stated that he could not remember what prompted him to show the video and other images. He said that he could not really recall what had led to it, explaining that they had been talking generally about different topics before he started scrolling through his mobile phone. He stated that this was not something he would normally do and that he does not usually share images with others.

27. Dr Dimitriadis stated that, when he read Ms A's statement, he felt angry with himself. He said, "I regret that I practically abused my senior position, so I brought Ms A into a position where she could not object." He stated that he genuinely feels sorry for placing her in that position.

Documentary Evidence

28. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included, but was not limited to witness statements, testimonials, CPD certificates, Screenshots of Whatapp messages and photographs.

Submissions

Submission on behalf of the GMC

29. Ms Fairley submitted that, when considering impairment, the Tribunal should have regard to the statutory overarching objectives of protecting and promoting the health, safety and well-being of the public, promoting and maintaining public confidence in the medical profession, and promoting and maintaining proper professional standards and conduct for members of the profession.

30. She referred the Tribunal to the relevant GMC guidance on impairment.

Step 2A – Legal Basis

31. Ms Fairley submitted that the first question for the Tribunal was whether there was a legal basis for a finding of impairment, referring the Tribunal to paragraphs 5 and 11 of the guidance.

32. She submitted that the facts admitted and found proved clearly represented behaviour amounting to a serious departure from the professional standards expected of a doctor, as set out in *Good Medical Practice*, and therefore amounted to serious misconduct. She noted that Dr Dimitriadis himself had acknowledged during his evidence that his conduct constituted serious misconduct.

Step 2B – Seriousness of the Conduct

33. Ms Fairley submitted that paragraph 30 of the guidance was relevant, as it concerns allegations that usually fall at the higher end of the spectrum of seriousness. She submitted that the present case engaged the guidance relating to an improper sexual or emotional relationship with a colleague, often arising where there is a close working relationship with an imbalance of power.

34. She acknowledged that the present case did not fall precisely within that category but submitted that it could properly be characterised as involving an attempted emotional

relationship with a colleague. She submitted that, by his own admission, Dr Dimitriadis had been "testing the waters" in relation to a potential future sexual relationship. She submitted that there was plainly a XXX working relationship between Dr Dimitriadis and Ms A and that there was an accepted imbalance of power between them.

35. Ms Fairley submitted that the misconduct included showing sexually explicit material to a significantly more junior colleague whilst both were on duty in a patient-facing clinical environment. She reminded the Tribunal that Ms A's evidence was that the incident occurred at the nurses' station on the ward.

36. Referring to paragraphs 34 and 36 of the guidance, Ms Fairley submitted that there were aggravating features which increased the seriousness of the misconduct. In particular, she submitted that the behaviour was persistent and repeated over a period of time rather than constituting a single isolated incident. She submitted that the conduct demonstrated a clear escalation in behaviour, beginning with generalised sexual comments about previous sexual encounters with nurses (Allegation 1), progressing to the comment that he intended to have sex with Ms A before returning to his home country (Allegation 2), and culminating in the deliberate display of explicit sexual images and videos of himself (Allegation 3).

37. She submitted that the abuse of Dr Dimitriadis's professional position was also a significant aggravating feature, given the accepted imbalance of power between Dr Dimitriadis and Ms A. Whilst she accepted there was no specific intention to undermine the working environment, she submitted that the conduct clearly had the potential to do so.

38. Ms Fairley referred the Tribunal to paragraph 43 of the guidance, submitting that where allegations fall at the higher end of the spectrum of seriousness, the presence of aggravating factors serves only to reinforce that assessment. She further relied upon paragraph 44, submitting that, in such cases, the starting point when assessing current and ongoing risk to public protection is that the risk will be high. She submitted that, where allegations are at the higher end of seriousness, evidence relating to the doctor's personal circumstances or subsequent response to the concerns generally carries less weight because such risks are inherently more difficult to mitigate.

Step 2C – Context

39. Ms Fairley acknowledged Dr Dimitriadis 's explanation that he had been new to working in the United Kingdom, had felt socially isolated and had failed to maintain appropriate boundaries between his professional and personal life.

40. However, she submitted that unfamiliarity with UK social norms could not justify his misconduct. She noted that although Dr Dimitriadis was relatively new to practising in the United Kingdom, he was nevertheless an experienced doctor. She submitted that paragraph 64 of the guidance specifically provides that a failure to meet expected professional standards is not excused simply because a doctor is new to UK practice.

41. She further submitted that paragraphs 67 and 73 reinforce that evidence relating to a doctor's role, experience or personal circumstances generally carries less weight where the allegations fall at the higher end of the spectrum of seriousness, as the resulting risk to public protection is more difficult to mitigate.

Step 2D – Insight, Remediation and Risk of Repetition

42. Ms Fairley submitted that Dr Dimitriadis had admitted the allegations in full and had acknowledged that his conduct was wrong. She accepted that he had demonstrated a degree of insight into why the misconduct had occurred and that he had accepted he should not have behaved as he did.

43. She also acknowledged that Dr Dimitriadis had, more recently, recognised the impact of his conduct upon Ms A. However, she submitted that aspects of his witness statements continued to place some responsibility upon Ms A by suggesting that he had been responding to what he perceived as her behaviour. She submitted that this represented an attempt, to some extent, to shift blame onto Ms A.

44. In relation to remediation, Ms Fairley acknowledged that Dr Dimitriadis had undertaken a number of professional courses, including one which addressed professional boundaries and sexual misconduct. However, she submitted that there remained some uncertainty as to the extent to which those courses had enabled him to explore fully the reasons for his misconduct. She noted that, during his oral evidence, Dr Dimitriadis had been unable to explain why he had shown the sexually explicit images and videos referred to in Allegation 3. She submitted that this raised questions about whether he had fully explored the underlying reasons for that behaviour.

45. Ms Fairley accepted that there did not appear to be deep-seated attitudinal concerns in this case and acknowledged that Dr Dimitriadis had demonstrated genuine insight and had taken steps towards remediation.

46. However, she referred the Tribunal to paragraph 109 of the guidance, which states that allegations falling at the higher end of the spectrum of seriousness and capable of

damaging public confidence are inherently more difficult to remediate. She submitted that the misconduct in the present case was plainly capable of significantly undermining public confidence in the medical profession.

Step 2E – Public Confidence and Professional Standards

47. Ms Fairley submitted that doctors occupy positions of privilege and trust within society and are expected to uphold the highest standards of professional conduct. She submitted that sexually motivated misconduct and the abuse of a senior professional position are particularly serious forms of misconduct which directly undermine public trust in the profession.

48. Accordingly, Ms Fairley submitted that a finding of current impairment was necessary in order to uphold proper professional standards and maintain public confidence in the medical profession.

Submissions on behalf of Dr Dimitriadis

49. Mr Lownds submitted that, in considering the spectrum of seriousness, the defence accepted the GMC's submission that the admitted sexually motivated misconduct placed the case within the higher end of the spectrum of seriousness. He submitted that Dr Dimitriadis had candidly admitted that, on reflection, he had been "testing the waters" in relation to Ms A, had accepted that his conduct was sexually motivated, and had admitted all of the allegations.

50. Mr Lownds submitted that the Tribunal was concerned with a number of admitted incidents involving sexually motivated words and behaviour, including the incident in which Dr Dimitriadis put his arm around Ms A and made a sexual comment, and the most serious allegation involving the inappropriate display of sexually explicit photographs and a video whilst at work. He accepted that the misconduct was repeated over a period of approximately 18 months to two years and involved an abuse of Dr Dimitriadis 's professional position, given the accepted imbalance of power between a doctor and a XXX.

51. Accordingly, Mr Lownds accepted that the starting point under the guidance was that the allegations fell at the higher end of the spectrum of seriousness.

52. However, Mr Lownds referred the Tribunal to paragraph 27 of the guidance, submitting that the initial assessment of seriousness may change when the Tribunal considers the full evidential picture, including factors which may decrease seriousness. He

submitted that, when the circumstances of this case were viewed in the round, there should be a downward adjustment in the assessment of seriousness. He emphasised that this submission did not detract from Dr Dimitriadis's admissions that the conduct was sexually motivated, constituted serious misconduct, and that he alone bore responsibility for maintaining appropriate professional boundaries.

53. Mr Lownds submitted that the case involved a single complainant and that sexually motivated misconduct covers a broad spectrum of behaviour. Whilst accepting the seriousness of the admitted conduct, he submitted that there was a distinction between the conduct in the present case and more serious forms of sexual misconduct involving physical sexual assault. He submitted that, save for the incident involving the explicit images and video, the conduct fell towards the lower end of that category.

54. In relation to the phone incident, which he accepted was the most serious allegation, Mr Lownds referred the Tribunal to paragraph 10 of Ms A's witness statement. He submitted that the incident lasted only a matter of seconds, comprising the display of a still image followed by a short video. He further referred to Ms A's investigative interview following her complaint, in which she stated that she had been shocked by what she had seen, that there was no audio playing, that patients could not hear any conversation, that no colleagues were present, and that only she had seen the material. He submitted that these factors were relevant to the Tribunal's assessment of the seriousness of that incident and demonstrated that it did not have a wider impact upon patients or colleagues.

55. Mr Lownds then addressed the circumstances surrounding the misconduct. He referred the Tribunal to Dr Dimitriadis 's witness statement, in which Dr Dimitriadis stated that it had been his responsibility to maintain appropriate professional boundaries, that he had failed to do so, that he deeply regretted his conduct, and that he apologised to both Ms A and the GMC.

56. Mr Lownds submitted that nothing advanced on behalf of Dr Dimitriadis was intended to excuse his behaviour or blame Ms A. Rather, he submitted that it was necessary to understand the context in which the misconduct occurred. He submitted that Dr Dimitriadis consistently accepted full responsibility for his actions and was not seeking to reduce his culpability by suggesting that Ms A bore any blame.

57. He referred the Tribunal to the WhatsApp communications between Dr Dimitriadis and Ms A, submitting that they demonstrated a friendly working relationship and workplace rapport between them. He also referred to evidence from colleagues describing Ms A as XXX. Mr Lownds submitted that this evidence was not relied upon to diminish Dr Dimitriadis 's

responsibility but to explain the context in which he had wrongly failed to maintain professional boundaries. He submitted that the nature of their friendship and the disinhibited environment in which they communicated were relevant to the Tribunal's assessment of the seriousness of the misconduct.

58. Mr Lownds also referred to Ms A's evidence regarding the impact of the misconduct. He submitted that, whilst Ms A found the conduct unwanted, embarrassing and shocking, she had stated during her investigative interview that she had not felt threatened by Dr Dimitriadis. He submitted that this was another factor relevant to the Tribunal's overall assessment of seriousness.

59. Accordingly, Mr Lownds submitted that, whilst the misconduct remained within the higher range because of its sexually motivated nature, repetition and abuse of professional position, it fell at the lower end of the higher range, or alternatively at the upper end of the middle range of seriousness.

60. Turning to context, Mr Lownds submitted that both Dr Dimitriadis 's personal circumstances and working environment were relevant to the Tribunal's assessment of impairment.

61. In relation to Dr Dimitriadis's personal circumstances, Mr Lownds submitted that this was a doctor with no previous fitness to practise history who had moved to the United Kingdom in 2022 and commenced work at the hospital in 2023. He submitted that Dr Dimitriadis had been living alone, had experienced loneliness and social isolation, and that his principal social interactions were within the workplace. He further submitted that Dr Dimitriadis had come from a different cultural background and had failed to familiarise himself adequately with the professional standards expected of doctors practising in the United Kingdom. He emphasised that Dr Dimitriadis accepted that this failure was entirely his responsibility and was not advanced as an excuse for his misconduct.

62. In relation to the working environment, Mr Lownds submitted that the Tribunal should consider the nature of Dr Dimitriadis 's friendship with Ms A alongside the positive testimonials provided by colleagues regarding his conduct with other members of staff. He submitted that those testimonials demonstrated that, during the same period, Dr Dimitriadis was regarded by others as a professional and supportive colleague. He submitted that this wider context was relevant when assessing both the seriousness of the misconduct and whether it was remediable.

63. Mr Lownds further submitted that the circumstances giving rise to the misconduct had fundamentally changed. Dr Dimitriadis no longer worked at the hospital, had not worked with Ms A since September 2024, XXX, and was no longer living in isolation. He submitted that these significant changes in Dr Dimitriadis 's personal circumstances reduced any current risk of repetition. He also noted that, following the final incident involving the phone, Dr Dimitriadis had continued working at the hospital for a period without any further allegations being made.

64. Turning to Dr Dimitriadis's response to the allegations, Mr Lownds submitted that, within one month of leaving his employment, Dr Dimitriadis had independently sought psychotherapy and had continued regular therapy sessions XXX. He submitted that the therapeutic process had enabled Dr Dimitriadis to explore the causes of his behaviour, understand his thinking at the time, develop insight into the impact of his actions, and learn from his mistakes.

65. Mr Lownds referred the Tribunal to the psychologist's report, which concluded that Dr Dimitriadis understood not only that his behaviour had been inappropriate, but also why it had been inappropriate within a professional healthcare environment. He submitted that the report demonstrated that Dr Dimitriadis had engaged in intensive reflection, accepted full responsibility for his actions without attributing blame to others, and had developed a clear understanding of professional boundaries and hierarchy. He submitted that the report further concluded that Dr Dimitriadis had engaged seriously with psychotherapy, had demonstrated accountability, possessed a strong capacity for self-reflection, and had demonstrably benefited from the therapeutic process.

66. Mr Lownds submitted that Dr Dimitriadis had also educated himself in relation to GMC guidance and professional standards, undertaken professional boundaries training shortly after the allegations arose, completed further training in March 2026, and produced detailed written reflections. He submitted that these steps had been undertaken promptly following the allegations and were not merely an attempt to impress the Tribunal.

67. Mr Lownds submitted that, over the previous two years, Dr Dimitriadis had consistently demonstrated genuine insight, taken responsibility for his misconduct, undertaken meaningful remediation, and significantly reduced the likelihood of repetition. He submitted that the misconduct was remediable, had in fact been effectively remedied, and that Dr Dimitriadis no longer presented a current or ongoing risk to public protection.

68. Finally, in relation to public confidence, Mr Lownds submitted that, having regard to Dr Dimitriadis 's admissions, genuine insight, remediation, low risk of repetition and previous

good character, a finding of current impairment was not necessary to maintain public confidence in the profession. He submitted that the public nature of the proceedings, together with a finding of serious misconduct and, if considered appropriate, the imposition of a warning, would be sufficient to uphold professional standards and maintain confidence in the medical profession.

69. Accordingly, Mr Lownds invited the Tribunal to find that Dr Dimitriadis 's fitness to practise was not currently impaired.

The relevant legal principles

70. The Tribunal was advised that, in determining impairment, it should ordinarily follow the *Guidance for MPTS Tribunals* (2025), including both the general guidance and the specific guidance on sexual misconduct, unless there was good reason to depart from it. The Guidance was not binding and the ultimate assessment remained a matter for the Tribunal's own professional judgment, based upon the particular facts and circumstances of the case. If the Tribunal departed from the Guidance, it should clearly explain its reasons for doing so.

71. The Tribunal was reminded that there were two stages to its decision-making. It must first determine whether the admitted facts amounted to misconduct. If it did not find misconduct, its consideration would end. If, however, it found misconduct, it must then determine whether Dr Dimitriadis's fitness to practise was currently impaired.

72. The Tribunal was advised that there was no burden or standard of proof at either the misconduct or impairment stage. Both were matters for the Tribunal's objective professional judgment. Although the GMC submitted, and Dr Dimitriadis accepted, that the admitted facts were capable of amounting to misconduct, the issue remained one for the Tribunal to determine.

73. The Tribunal was referred to *Roylance v General Medical Council* [2000] (No. 2) 1 AC 311, in which misconduct was described as conduct falling short of what would be proper in the circumstances. The Tribunal was reminded that the standards against which the conduct should be judged were those expected of a registered medical practitioner, principally as set out in *Good Medical Practice (in force from 22 April 2013 until 30 January 2024)*.

74. The Tribunal was reminded that, applying the principles in *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), as approved in *Meadow v General Medical Council* [2007] QB 462, a departure from professional standards does not automatically amount to misconduct. The departure must be a serious one, and the word "serious" should be given its ordinary meaning. If the Tribunal concluded that the admitted conduct did not amount to a

serious departure from the standards expected of a registered doctor, there would be no finding of misconduct and its consideration would end.

75. The Tribunal was advised that, if it found misconduct, it should then proceed to consider impairment by applying the staged approach contained within the Guidance, in particular Steps 2B to 2E. Whilst the Guidance was not binding, any departure from it should be approached with caution and fully explained.

76. The Tribunal was reminded that, in considering impairment, it must have regard to all three limbs of public protection, namely the protection of patients and the wider public, the maintenance of public confidence in the profession, and the promotion and maintenance of proper professional standards and conduct. The Tribunal was advised that a finding of impairment is not confined to cases involving a current risk of patient harm. Even where the risk of repetition is low, a finding of impairment may nevertheless be required to maintain public confidence in the profession or uphold proper professional standards.

77. The Tribunal was also referred to the questions derived from Dame Janet Smith's Fifth Shipman Report and adopted in *CHRE v NMC and Grant* [2011] EWHC 927 (Admin), namely whether the doctor had in the past acted, or was liable in the future to act, so as to place patients at unwarranted risk of harm, bring the profession into disrepute, or breach one of the fundamental tenets of the profession. The Tribunal was advised that the fourth *Grant* question concerning dishonesty did not arise on the facts of this case. It was reminded that these questions are not intended as a checklist and that no single factor was determinative.

78. The Tribunal was further advised that, under Step 2B of the Guidance, it should assess the seriousness of the misconduct, identify any aggravating or mitigating features, and determine where the conduct fell on the spectrum of seriousness. That assessment would inform its evaluation of current and ongoing risk. The Tribunal was reminded that the Guidance indicates that sexually motivated misconduct will generally fall towards the higher end of the spectrum of seriousness.

The Tribunal's determination on impairment

<u>Is there a legal basis for considering impairment?</u>

79. The Tribunal determined that Dr Dimitriadis's misconduct towards Ms A occurred within the workplace and accepted Dr Dimitriadis's admission that his conduct represented a serious departure from the standards expected of a registered medical practitioner. The Tribunal further found that the conduct amounted to sexual misconduct because of its effect

on Ms A, notwithstanding that sexual misconduct was not Dr Dimitriadis 's stated intention at the time.

80. The Tribunal concluded that Dr Dimitriadis's actions breached paragraphs 35, 36, 37 and 65 of GMP, which state:

> *35 You must work collaboratively with colleagues, respecting their skills and contributions.*
>
> *36 You must treat colleagues fairly and with respect.*
>
> *37 You must be aware of how your behaviour may influence others within and outside the team.*
>
> *65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession*

81. The Tribunal found that Dr Dimitriadis was "*testing the waters*" and that his behaviour had escalated over time particularly in relation to allegations two and three. It concluded that showing explicit photographs and video imagery (of himself) to a junior colleague was wholly inappropriate. Having regard to the relevant paragraphs of *Good Medical Practice* (GMP), the Tribunal considered that these standards were engaged given the nature, seriousness, and pattern of Dr Dimitriadis's conduct towards a junior colleague.

82. The Tribunal determined that Dr Dimitriadis 's conduct, comprising sexual misconduct together with an abuse of his senior position, constituted a serious departure from the standards expected of a registered medical practitioner. It considered that fellow practitioners would regard such behaviour as unacceptable. Accordingly, the Tribunal was satisfied that the misconduct found proved was sufficiently serious to establish a legal basis for a finding of impairment. It then proceeded to consider where the misconduct fell on the spectrum of seriousness.

<u>Where on the spectrum of seriousness does the allegation lie?</u>

83. The Tribunal considered the submissions made by both parties. Ms Fairley submitted that the misconduct fell at the higher end of the spectrum of seriousness, whereas Mr Lownds submitted that it fell within the lower-mid range.

84. The Tribunal also had regard to the Introduction to the Guidance, which indicates that cases involving sexual misconduct will usually fall at the higher end of the spectrum of seriousness because of the significant risk they pose to public confidence in the profession.

> *66. Most allegations relating to sexual misconduct have a starting point of a high level of seriousness and therefore fall at the higher end of the spectrum of seriousness. This means the starting point for assessing current and ongoing risk to public protection will usually be high.*
>
> *69. The level of risk associated with a sexual misconduct allegation will generally be medium or high.*

85. The Tribunal determined that the appropriate starting point for assessing the seriousness of this case was at the higher end of the spectrum. It had regard to paragraph 31 of the Guidance, which identifies sexual misconduct as a type of misconduct that will usually be regarded as falling within the higher range of seriousness.

86. The Tribunal further concluded that the case fell within Case Type 1: Sexual Misconduct as described in the Introduction to the Guidance. It considered that Dr Dimitriadis 's conduct latterly created an uncomfortable working environment for Ms A. Showing Ms A explicit photographs and videos of himself, together with his physical conduct and disregard for her discomfort, represented a serious breach of professional boundaries.

> *'63 Whilst a range of behaviour can be seen, the nature of the departure from the professional standards usually means these concerns or allegations fall at the higher end of the spectrum of seriousness. Even a single incident of sexual misconduct can have a significant harmful impact and pose a high level of risk to public protection.'*

87. The Tribunal also considered whether Dr Dimitriadis had exploited the imbalance of power that existed between himself, as a senior clinician, and Ms A. Whilst there was no evidence of coercion amounting to abuse of authority in the strict sense, the Tribunal found that his seniority was a relevant aggravating feature. In relation to the production of the explicit imagery of himself, his conduct could reasonably be perceived as predatory. There was no relevant context at that time. The Tribunal had particular regard to Ms A's evidence that Dr Dimitriadis appeared to derive amusement from her reaction, which demonstrated a disregard for her dignity and wellbeing.

88. In assessing the overall seriousness, the Tribunal considered that the misconduct presented a high level of risk to public confidence in the medical profession and to maintaining proper professional standards. Although the misconduct did not present the

highest level of risk to patient safety, as it was directed towards a colleague rather than a patient, it nevertheless had the potential to cause significant emotional harm and undermine confidence in doctors as professionals.

89. Taking all of these matters into account, the Tribunal concluded that the misconduct lay within the mid-range of the higher end of the spectrum of seriousness. While the case did not involve physical sexual assault or prolonged coercive behaviour, the repeated sexual motivated conduct of a colleague, the abuse of professional boundaries, the imbalance of seniority, and the potential emotional harm placed the misconduct firmly within the higher category identified by the Guidance.

What is the impact of any relevant context known about Dr Dimitriadis and/or their working environment?

90. The Tribunal considered the impact of the relevant contextual factors surrounding Dr Dimitriadis 's misconduct.

91. In relation to his working environment, the Tribunal noted that this was Dr Dimitriadis's first role in the UK and within the NHS. However, it also noted that he was not employed as a junior doctor but as a senior clinician. As such, the Tribunal considered that he was expected to understand and maintain appropriate professional standards and boundaries in the workplace.

92. The Tribunal had regard to paragraph 64 of the guidance:

> *64 Failure to meet the professional standards expected is not acceptable simply because a doctor is newly qualified or new to UK practice. However, where they are inexperienced at the time the behaviour or poor performance occurred and can demonstrate that since then they have developed their skills or gained a better understanding of the UK healthcare system, this may decrease the level of current and ongoing risk they pose to public protection because it reduces the likelihood of repetition.*

93. In relation to Dr Dimitriadis 's personal circumstances, the Tribunal had regard to his written statement. Dr Dimitriadis stated that, as someone who was new to the UK, a young man who was isolated and unfamiliar with the social environment, and who came from a culture where hugging was considered natural, he had not appreciated that aspects of his behaviour were inappropriate. The Tribunal accepted that these factors provided some context for his actions.

94. However, the Tribunal found that these contextual factors could not explain or justify the more serious aspects of his misconduct. In particular, the Tribunal considered that showing a colleague explicit photographs and videos was conduct that Dr Dimitriadis must have known fell well outside the boundaries of acceptable workplace behaviour, regardless of cultural background or unfamiliarity with the UK.

95. The Tribunal also noted that, initially, Dr Dimitriadis sought to attribute responsibility for his misconduct to Ms A, suggesting that she prompted if not actually encouraged his behaviour. Having considered the screenshots of the messages exchanged between Dr Dimitriadis and Ms A, together with the witness statements, the Tribunal accepted that there was interaction between them which extended beyond a purely professional working relationship. Nevertheless, the Tribunal found that Dr Dimitriadis was responsible for his own conduct and could not shift responsibility onto Ms A.

96. The Tribunal further considered that Dr Dimitriadis's behaviour had the potential to cause significant emotional harm to Ms A.

97. Overall, whilst the Tribunal accepted that there were contextual factors which helped explain how the misconduct arose, it did not find that they provided any justification or excuse for Dr Dimitriadis 's actions. A reasonable person in Dr Dimitriadis 's position would have understood that such conduct was inappropriate and unacceptable within a professional workplace. Moreover, as Dr Dimitriadis has accepted as a senior professional, his conduct was his personal responsibility irrespective of the conduct of others.

How has Dr Dimitriadis responded to the allegation?

98. The Tribunal considered the Guidance at paragraph 134:

> *134. In cases where the allegation falls at the higher end of the spectrum of seriousness, the starting point for assessing current and ongoing risk to public protection will be high. Evidence of relevant context that decreases risk and evidence of insight and remediation that decreases risk may have less impact and carry less weight because these types of allegations can be more difficult to remediate. Evidence of the doctor having kept their knowledge and skills up to date may also be less relevant. This should be considered by the MPT when they are reaching a view on risk and a conclusion that the doctor poses a current and ongoing risk to one of more of the three parts of public protection requiring restrictive action in response may be needed, particularly as the allegation is likely to engage public confidence.*

99. The Tribunal had regard to Dr Dimitriadis 's witness statement, his oral evidence, and the full admissions to the allegation. It noted that, although Dr Dimitriadis did not initially accept full responsibility for his conduct and sought, in part, to attribute responsibility to Ms A, his position developed over time.

100. In considering the level of insight, the Tribunal was mindful of the Guidance, which states:

> *81. To demonstrate insight, and insight which is genuine, the doctor will need to show they understand what happened and accept how they could have acted differently. This involves showing, where relevant, that they have:*
>
> - *considered the allegation, understanding what went wrong and accept they should have acted differently*
> - *fully understood the impact or potential impact of their behaviour, performance, or health condition*
> - *empathy for any individual affected, for example by apologising*
> - *taken, or are taking, steps to remediate and to identify how they will act differently in the future to avoid similar issues arising*
>
> *…*
>
> - *co-operated with earlier investigations into the allegation (if they had the opportunity to do so) and engaged with the GMC's investigation, and/or*
>
> *self-referred to their employer and/or the GM*

101. The Tribunal found that Dr Dimitriadis has since demonstrated genuine remorse and has taken significant steps to understand and address his behaviour. It noted that he has engaged in therapy, completed a three-day professional boundaries course, and undertaken one-to-one reflective work focused on his conduct and professional responsibilities. Through these interventions, Dr Dimitriadis has developed a much greater understanding of appropriate professional boundaries, the nature of sexual harassment, and the standards expected of a doctor working within the NHS

102. The Tribunal considered that Dr Dimitriadis has demonstrated meaningful and developing insight into the seriousness of his misconduct. In his written reflections, he acknowledged that his behaviour caused Ms A intimidation, distress and discomfort, particularly through showing explicit photographs and videos of himself. He also

demonstrated an understanding that his conduct had the potential to undermine the working environment and potentially adversely affect junior colleagues who may have felt unable to challenge the behaviour of a more senior clinician because of the imbalance of power between them.

103. The Tribunal was satisfied that Dr Dimitriadis had reflected on how he could and should have acted differently. It considered that he had demonstrated a sufficient understanding of the impact of his misconduct on public confidence in the medical profession and on the need to maintain proper professional boundaries at all times.

104. The Tribunal also considered the Guidance in respect of remediation, which states:

99. Remediation can take several forms, including, but not limited to:

…

- *where the allegation relates to behaviour, attending courses relevant to the nature of the matters raised and showing that the learning has been applied*
- *evidence that shows what the doctor has learnt following the events that led to the allegation, and how they have applied this learning in their practice*
- *evidence of good practice in a similar environment to where the allegation arose – this will often be evidence from a doctor's employer showing that they were aware of the allegation and have evaluated the doctor's practice*

105. In considering remediation, the Tribunal recognised that sexual misconduct is often regarded as particularly difficult to remediate. Nevertheless, it was satisfied that, in the circumstances of this case, Dr Dimitriadis had undertaken substantial and meaningful remediation. His detailed written reflections demonstrated that the therapy and educational courses had materially enhanced his understanding of sexual misconduct and harassment in the workplace and had led to sustained behavioural change.

106. The Tribunal also had regard to the testimonials provided on Dr Dimitriadis 's behalf. It considered these to be relevant, as they described his professional conduct following the events in question and demonstrated evidence of safe and appropriate practice in a similar clinical environment. The Tribunal noted that Dr Dimitriadis has continued to work with junior colleagues without any further concerns or complaints arising.

107. Overall, the Tribunal was satisfied that Dr Dimitriadis has demonstrated genuine and well-developed insight into his misconduct and has taken appropriate and sustained steps to

remediate his behaviour. It considered that these factors significantly reduced the risk of repetition.

108. In considering the risk of repetition, the Tribunal weighed the evidence of Dr Dimitriadis 's insight and remediation alongside the remaining areas of concern. It acknowledged that Dr Dimitriadis had engaged meaningfully with remediation through therapy, professional boundaries training and detailed written reflections, all of which demonstrated a developing understanding of the seriousness of his misconduct and the impact it had on Ms A, the working environment and public confidence in the profession.

109. However, the Tribunal was not satisfied that there was sufficient evidence to conclude that the risk of repetition was low. In particular, when questioned about why he had shown Ms A the explicit photographs and videos, Dr Dimitriadis stated that he could not recall his reasons, given the passage of time. The Tribunal was concerned that Dr Dimitriadis had not been able to identify or fully explore the underlying factors that led to his behaviour. Whilst the Tribunal accepted that he had reflected extensively on the consequences of his actions, it was not persuaded that he had demonstrated complete insight into the root cause of his misconduct or the circumstances that gave rise to it.

110. Accordingly, although the Tribunal was satisfied that Dr Dimitriadis had made significant progress in developing insight and undertaking meaningful remediation, it concluded that there remained a risk of repetition. The Tribunal considered that the evidence demonstrated genuine efforts at remediation, but that further development of insight into the underlying causes of his behaviour was required before the risk of repetition could properly be regarded as low.

Tribunal's decision as to whether Dr Dimitriadis poses any current and ongoing risk to public protection which may require restrictive action in response and its finding on impairment

111. The Tribunal concluded that Dr Dimitriadis's misconduct was initially assessed as falling within the mid-range of the high end of seriousness. However, in light of his insight and remediation, the Tribunal determined that the misconduct ultimately fell within the medium range of the spectrum of seriousness.

112. In reaching its decision, the Tribunal was mindful of the following paragraph of the Guidance:

> *68. In such [sexual misconduct] cases the MPT's decision on risk should reflect this and a conclusion that the doctor poses a current and ongoing risk to public protection may be needed even in cases where the doctor has shown insight and taken steps to try*

and remediate. Where the MPT concludes that the doctor poses a current and ongoing risk, this will result in them finding that the doctor's fitness to practise is impaired.

113. The Tribunal concluded that given its finding of sexual misconduct, all three limbs of public protection were engaged. In light of the fact that the most serious of the allegations took place in a clinical setting when patients were nearby, the Tribunal determined that public confidence in the profession; and proper professional standards and conduct for members of the profession would be undermined were a finding of impairment not made. The Tribunal also considered there was indirect risk to patient safety from behaviour that had the potential to undermine collaborating working.

114. The Tribunal also considered the test set out in *Grant*, above, and concluded that Dr Dimitriadis 's conduct had in the past brought the profession into disrepute; and had in the past breached one of the fundamental tenets of the profession.

115. In all the circumstances the Tribunal determined that a finding of impairment was necessary in order to mark the seriousness of the findings and send a signal to Dr Dimitriadis and the wider profession that such behaviour is not acceptable and will not be tolerated.

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

Determination on Sanction - 22/07/2026

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

The evidence

118. The Tribunal has reviewed its findings at the facts and impairment stages and taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

Submissions

119. On behalf of the GMC, Ms Fairley submitted that the Tribunal had found all three limbs of the overarching objective to be engaged.

120. She referred the Tribunal to paragraph 10 of the Guidance, which provides that any sanction imposed must be proportionate, transparent, and fair. However, she emphasised that the third bullet point of paragraph 10 makes clear that established case law provides that the need to protect the public outweighs the interests of an individual doctor

121. Turning to the relevant sanction bands, Ms Fairley submitted that paragraph 62 of the Guidance specifically addresses cases involving sexual misconduct. Where there is a medium level of risk, the appropriate sanction is suspension for between six and twelve months. Where there is a higher level of risk, the appropriate sanction ranges from twelve months' suspension to erasure.

122. She submitted that the Tribunal's findings on impairment demonstrated that this case fell within the higher category. In particular, the Tribunal had found that the sexual misconduct was aggravated by an imbalance of power between the doctor and Miss A. In relation to Allegation 3, the Tribunal found at paragraph 87 that the doctor's conduct could reasonably be perceived as predatory and that he appeared to derive amusement from Miss A's reaction.

123. Ms Fairley further submitted that, as set out at paragraph 89 of the Tribunal's determination, the doctor's conduct amounted to repeated sexual misconduct and constituted an abuse of professional boundaries. There was a clear imbalance in seniority, and the doctor's conduct had the potential to cause Miss A emotional harm.

124. She also relied upon paragraph 73 of the determination, which identified significant aggravating features, and paragraph 81, where the Tribunal found that the doctor's behaviour had escalated over time.

125. In those circumstances, she submitted that any sanction short of erasure would be insufficient. Ms Fairley referred to paragraph 57(d) of the Guidance, which provides that erasure is appropriate where the seriousness of the facts found proved is such that allowing the doctor to remain on the register would undermine public confidence in the medical profession.

126. She submitted that this was such a case. It involved repeated, sexually motivated misconduct, accompanied by significant aggravating features, including an abuse of power, predatory behaviour, and an escalation of misconduct over time. Accordingly, the GMC invited the Tribunal to impose a sanction of erasure.

The Tribunal's determination on sanction

127. On behalf of Dr Dimitriadis, Mr Lownds submitted that the Guidance makes clear that the available sanctions and indicative bandings are no more than a guide. The Tribunal is required to consider the individual circumstances of the case, and there may be features

which justify a sanction falling either below or above the indicative range. Against that background, he submitted that, having regard to the Tribunal's findings, the appropriate starting point in this case was a period of suspension in the range of six to twelve months, rather than erasure.

128. He submitted that such an outcome was entirely consistent with the Tribunal's findings on impairment, as set out in paragraph 111 of its determination. He argued that a period of suspension would represent a proportionate response to the residual risk identified by the Tribunal and would appropriately reflect the need for further remediation before Dr Dimitriadis returned to unrestricted practice.

129. In support of that submission, Mr Lownds reminded the Tribunal of its earlier findings. He noted that the Tribunal had assessed the misconduct as falling within the mid-range of the higher end of seriousness. He submitted that the Tribunal had then undertaken a careful assessment of Dr Dimitriadis's conduct and progress since the events in question.

130. He drew particular attention to the Tribunal's findings that Dr Dimitriadis had demonstrated genuine remorse (paragraph 101), shown meaningful and developing insight (paragraph 102), provided satisfactory reflection on the extent to which his behaviour had contravened professional standards (paragraph 103), demonstrated substantial and meaningful remediation (paragraph 105), and provided evidence that he had subsequently worked in a safe and appropriate manner (paragraph 106).

131. He submitted that these were all findings made by the Tribunal after hearing oral evidence, considering extensive documentary evidence and receiving detailed submissions. Those findings, he argued, demonstrated significant rehabilitation and weighed heavily against the imposition of the most severe sanction.

132. Mr Lownds further submitted that Dr Dimitriadis had accepted full responsibility for the sexual misconduct allegation from the point at which it was first raised. Whilst acknowledging the Tribunal's findings at paragraphs 109 and 110 that further work remained necessary to achieve full insight into the underlying causes of his conduct, he emphasised that the Tribunal had not found an absence of insight. Rather, it had recognised that extensive progress had already been made and that only one important area required further development in order to reduce the risk of repetition to a low level. He submitted that this finding explained why impairment remained established, but equally supported the conclusion that suspension, rather than erasure, was the appropriate sanction.

133. He also relied upon the testimonials contained within the hearing bundle submitted on behalf of Dr Dimitriadis, which spoke positively of his clinical skills, professionalism and conduct in the workplace. He submitted that there had been no criticism of Dr Dimitriadis's

clinical competence and that those testimonials demonstrated that the misconduct did not reflect his wider professional practice or character.

134. Turning to the proportionality of erasure, Mr Lownds submitted that the Tribunal was entitled to take into account the profound consequences that such a sanction would have upon Dr Dimitriadis. Erasure would have a significantly greater impact upon his professional reputation, permanently deprive him of his livelihood, and carry particular consequences XXX. More importantly, he submitted that permanent removal from the register would frustrate the very process of remediation which the Tribunal had found to be ongoing and meaningful, thereby undermining the prospect of Dr Dimitriadis safely returning to unrestricted practice following further development of his insight.

135. Mr Lownds submitted that the guidance relating to suspension reflected precisely the circumstances of this case. The Guidance makes clear that suspension is intended for cases where a doctor is currently unable to practice without restriction, where the deficiencies are capable of remediation and there remains a realistic prospect of a safe return to practice.

136. He submitted that this was entirely consistent with the Tribunal's own findings. Whilst accepting that patient safety remained a relevant consideration because all three limbs of impairment had been engaged, he argued that the Tribunal's reasoning demonstrated that its principal concerns lay in maintaining public confidence in the profession and upholding proper professional standards. A period of suspension would adequately address those concerns whilst allowing Dr Dimitriadis the opportunity to complete the further work identified by the Tribunal.

137. He further submitted that suspension would appropriately mark the seriousness of the misconduct and send a clear signal that such behaviour was unacceptable. It would prevent Dr Dimitriadis from practising whilst he continued to develop insight into the underlying causes of his conduct and would therefore achieve the objectives of both public protection and public confidence.

138. In contrast, Mr Lownds submitted that erasure is reserved for the most serious cases, particularly those involving a persistent lack of insight, a failure to remediate, or an ongoing unwillingness to accept responsibility. He submitted that none of those features was present in this case. On the contrary, Dr Dimitriadis had admitted the misconduct, demonstrated genuine remorse, undertaken extensive reflection, engaged meaningfully with remediation, and shown that he was capable of practising safely. In those circumstances, he submitted that a fair-minded and informed member of the public, reading the Tribunal's findings on impairment, would not conclude that erasure was the only proportionate outcome.

139. Finally, in relation to the appropriate period of suspension, Mr Lownds submitted that any suspension should fall towards the lower end of the six to twelve month range, reflecting

the substantial remediation already achieved and the relatively limited area of outstanding insight identified by the Tribunal. Whilst he did not oppose the imposition of a review hearing, recognising that the Tribunal might wish to assess the extent to which the remaining work had been completed, he submitted that if the Tribunal considered that the suspension was imposed principally to maintain public confidence, rather than because of a continuing risk to the public, it might conclude that a review was unnecessary.

140. Accordingly, Mr Lownds submitted that a period of suspension represented the proportionate and appropriate sanction in this case, properly balancing the seriousness of the misconduct with the substantial evidence of remorse, insight, remediation and the realistic prospect that Dr Dimitriadis would be able to return safely to unrestricted practice following completion of the remaining work identified by the Tribunal.

Tribunal decision

141. The LQC advised the Tribunal that, when determining sanction, it should have regard to the relevant MPTS guidance, in particular Section 3, Part C of the Guidance, together with the specific guidance relating to sexual misconduct and the applicable sanctions bandings.

142. The LQC advised that the purpose of any sanction is to achieve the overarching objective of the proceedings, namely public protection. That objective comprises three elements: protecting patients and the wider public; maintaining public confidence in the medical profession; and promoting and maintaining proper professional standards and conduct.

143. The Tribunal was advised to consider the available sanctions in ascending order of seriousness, beginning with the least restrictive option, whilst applying the principle of proportionality throughout. Any sanction imposed should be proportionate, transparent and fair. In determining whether a sanction was required, and, if so, which sanction was appropriate, the Tribunal should balance the public interest against the impact of any sanction upon Dr Dimitriadis, including the effect on his career, reputation and professional circumstances.

144. The LQC observed that a particular sanction may have a greater impact on one doctor than another because of their individual circumstances. However, the Tribunal was reminded that the authorities make clear that the need to protect the public outweighs the interests of the individual doctor. Although sanctions are not intended to punish or discipline, they may nevertheless have a punitive effect while remaining necessary and proportionate to achieve the overarching objective.

145. The LQC reminded the Tribunal that the available sanctions, in ascending order of seriousness, were: taking no action, imposing conditions on registration, suspension and

erasure. The LQC provided a summary of the Guidance relating to the sanctions mentioned by both parties.

146. In relation to suspension, the LQC advised that it may be appropriate where the concerns are too serious to be addressed by conditions but are not so serious as to require erasure. Suspension may be suitable where there has been a serious departure from professional standards but the doctor has demonstrated insight, acknowledged their failings and there remains a realistic prospect of remediation. In deciding whether suspension was appropriate, the Tribunal should consider the seriousness of the misconduct, the risk posed to patients and the wider public, the risk of repetition, the doctor's level of insight and remediation, and whether a lesser sanction would sufficiently meet the overarching objective.

147. If the Tribunal decided to impose suspension, it should determine an appropriate period, up to a maximum of twelve months. In selecting the duration, it should consider the seriousness of the findings, the need to protect the public, maintain public confidence and uphold professional standards, together with the aggravating and mitigating factors and the time reasonably required for remediation. The Tribunal should explain why the period selected was necessary and proportionate.

148. The LQC further advised that, where suspension is imposed, the Tribunal should consider whether a review hearing is required. It is important that a doctor is not permitted to return to unrestricted practice unless a tribunal is satisfied that it is safe for him to do so.

149. Turning to erasure, the LQC advised that this is the most serious sanction available. Erasure may be appropriate where a doctor's conduct is fundamentally incompatible with continued registration or where it is necessary to maintain public confidence in the profession and uphold proper professional standards. Factors which may indicate that erasure is appropriate include a particularly serious departure from professional standards, an abuse of trust, or serious sexual misconduct, although those factors are not exhaustive and the Tribunal may identify other case-specific considerations.

150. The LQC advised that the key question for the Tribunal was whether the conduct was so serious that neither conditions nor suspension would be sufficient to protect the public, maintain public confidence in the profession, or uphold proper professional standards. Before reaching its final decision, the Tribunal should also consider the next most serious available sanction before concluding that a particular sanction was appropriate.

Sanction

151. In reaching its decision on the appropriate sanction, the Tribunal had regard to paragraphs 50, 51, 52 and 54 of the Introduction to the Guidance, which states in relation to Case Types involving sexual misconduct.

> *50 .Sexual misconduct may take the form of uninvited or unwelcome behaviour of a sexual nature – or which can be reasonably interpreted as sexual – that offends, embarrasses, harms, humiliates or intimidates an individual. It encompasses elements of harassment and abuse, can be physical, verbal or visual. It can be carried out, and experienced by, anyone regardless of socioeconomic background or protected characteristics.*
>
> *51 sexual misconduct may be sexually motivated, meaning it could be for the doctor's gratification, but won't always be. Where there is no clinical justification for touching a patient or member of the public (which includes a colleague) in a sexual way, or a way that could be perceived as sexual, then it will usually be appropriate to find sexual motivation.*
>
> *52 Behaviour amounting to sexual misconduct can arise inside or outside a doctor's working life. When sexual misconduct arises in a doctor's working life, their behaviour may be directed towards patients, former patients, relatives of patients, or colleagues.*
>
> *54. A relationship, or pursuit of a relationship, between colleagues may be inappropriate where there is an imbalance of power6, or where training and career progression opportunities could be affected, and that is misused. The pursuit of a relationship with a colleague could also amount to sexual misconduct where the pursuit continues in the absence of clear reciprocation, even where there is no imbalance of power.*

152. When deciding on sanction, the Tribunal had regard to the sanctions banding for sexual misconduct cases in Part C of Section 3: MPT hearings.

Lower level of risk to public protection	*Medium level of risk to public protection*	*Higher level of risk to public protection*
Suspension up to 6 months	*Suspension 6 to 12 months*	*Suspension 12 months to Erasure*

No action

153. The Tribunal first considered whether to conclude the case by taking no action. It considered paragraphs 13 – 16 of Section 3 of the MPTS Guidance which relate to consideration of 'Taking no action'. It noted in particular paragraph 13 states:

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

154. It determined that there were no exceptional circumstances in this case which could justify it taking no action. It noted that neither party submitted taking no action would be appropriate or proportionate in the circumstances of this case and that this fell well below the indicative sanction banding.

155. Given the serious findings against Dr Dimitriadis, the Tribunal determined that to take no action would be neither appropriate nor proportionate given its earlier findings and would fail to uphold the statutory overarching objective.

Conditions

156. The Tribunal next considered whether to impose conditions on Dr Dimitriadis's registration. It bore in mind that any conditions imposed would need to be appropriate, workable, measurable and proportionate and it reminded itself of the relevant paragraphs of the guidance:

> *17. Conditions are suitable for those cases where the doctor's behaviour, performance, or the impact that a health condition is having on their ability to practise safely and effectively, is currently incompatible with unrestricted registration. This means the current and ongoing risk to public protection posed by the doctor needs to be managed by restricting their registration for a period of time, with the aim they should be able to safely return to unrestricted practice in the future.*
>
> *…*
>
> *20. Where conditions are put in place, they should be appropriate, workable, and measurable.*
>
> *21. To be appropriate, conditions must address the specific findings about the current and ongoing risk to public protection posed by the doctor.*
>
> *…*
>
> *23. Conditions are likely to be workable where:*
>
> *a. the doctor has shown insight*

b. time is needed for the doctor to take steps to address the findings (remediate), for example through retraining, study, supervision and/or seeking medical treatment

c. the doctor is willing to remediate, and

the MPT is satisfied the doctor will comply with them

157. The Tribunal considered the sanctions bandings for cases where there is a medium level of risk to public protection and noted that it does not indicate that conditions would be sufficient to meet the level of risk identified in this case.

158. The Tribunal also considered that it would not be possible to formulate workable conditions in relation to the misconduct found in this case. Further, even if workable conditions could be formulated, these would not be proportionate and would fail to maintain public confidence and uphold professional standards in light of the seriousness of the findings.

Suspension

159. The Tribunal then went on to consider whether to impose a period of suspension. In doing so it considered the following paragraphs of the Guidance.

44. Restrictive action of suspension is intended to address the level of current and ongoing risk to public protection and is not intended to be punitive. However, as it prevents a doctor from working and earning a living within that profession, it can have this effect. Suspension can also have a deterrent effect and be used to send a signal to the individual doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor.

45. Suspension may be proportionate in cases where some, or all, of the following factors are present:

a. conditions are not appropriate, measurable and/or workable

b. the level of current and ongoing risk to public protection is such that it cannot be safely managed with conditions and suspension is necessary to stop the doctor from working and putting patients at risk while they gain insight into any deficiencies and remediate, or undergo medical treatment, and/or

c. the level of current and ongoing risk to public protection is such that, although patient safety is not an issue, suspension is needed to maintain public confidence in the profession and/or maintain professional standards.

160. The Tribunal reminded itself of the relevant sanctions banding for cases involving misconduct, which indicates that a period of suspension of between six and twelve months may be appropriate, depending upon the particular circumstances of the case. It also reminded itself of its earlier finding that Dr Dimitriadis's misconduct fell within the medium range of the spectrum of seriousness, having regard to the nature of the conduct and the contextual factors identified during the impairment stage.

161. The Tribunal took into account its findings on insight and remediation. It accepted that Dr Dimitriadis had demonstrated genuine remorse, meaningful and developing insight, and had undertaken substantial remediation. Whilst the Tribunal had concluded that further work remained necessary to develop a fuller understanding of the underlying causes of his misconduct, it was satisfied that his conduct was capable of remediation and that he had made significant progress towards that objective.

162. The Tribunal also had regard to the testimonial evidence before it. The testimonials demonstrated that he had continued to practise professionally and appropriately following the misconduct, both at the original work setting and subsequently in Greece for a significant period with no further concerns being raised about his conduct or clinical practice. The Tribunal also noted that the GMC accepted in its submissions at the impairment stage that there was insufficient evidence to support deep-seated attitudinal concerns regarding Dr Dimitriadis's practice or professionalism.

163. The Tribunal further took into account the practical steps Dr Dimitriadis had undertaken to remediate his misconduct. These included engaging in therapeutic work, implementing safeguards within his professional practice, reflecting extensively upon his behaviour, and maintaining an unblemished professional record during the significant period that had elapsed since the events giving rise to these proceedings. The Tribunal was satisfied that the absence of any further concerns during that period provided further persuasive evidence that his remediation was genuine and ongoing.

164. Having regard to the Guidance, and in particular the importance of the three limbs of public protection, the Tribunal concluded that a period of suspension was the necessary and proportionate sanction. However, whilst the Tribunal accepted that Dr Dimitriadis had made substantial progress towards remediation and had demonstrated developing insight into his misconduct, it was not satisfied that the risk of repetition had been entirely eliminated. The Tribunal also considered that, although the evidence demonstrated meaningful remediation, the process remained incomplete. Accordingly, the Tribunal identified a residual risk that, until the root cause of his conduct is identified and addressed, then in circumstances of a similar nature, Dr Dimitriadis may revert to the behaviours that gave rise to the concerns in this case. If realised, that risk could indirectly expose patients to harm and undermine public confidence in the profession.

165. The Tribunal also considered the wider public interest. It determined that a period of suspension was required to maintain public confidence in the medical profession and the regulatory process, and to uphold proper professional standards and conduct. The Tribunal was satisfied that these objectives could be adequately met by a suspension order.

Erasure

166. The Tribunal considered whether erasure might be an appropriate sanction. It reminded itself of paragraph 57 of the guidance:

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

167. The Tribunal was satisfied that none of these factors were present in this case and that erasure would be disproportionate and unduly punitive in the circumstances. Given Dr Dimitriadis's developing insight and elements of remediation that the Tribunal had identified in its determination on impairment, the Tribunal concluded that Dr Dimitriadis's conduct is not incompatible with continued registration.

Length of suspension

168. In determining the length of suspension, the Tribunal had regard to paragraph 63 of the relevant section of the MPTS Guidance which states:

> *'63 In all cases, once the MPT has identified the level of banding, they will need to decide the appropriate length of sanction to impose within that range provided they are satisfied it is the most proportionate type of action considering the individual circumstances of the case. The following factors will be relevant to deciding the appropriate length of time that conditions or suspension should be put in place for:*
>
> *a the reasons for assessing conditions or suspension as being the proportionate response*

b the amount of time the doctor is likely to need to remediate, complete treatment for and/or recover from a health condition that is having, or likely to have, an impact on their ability to practise safely and effectively

c where a condition has been imposed that requires a doctor to complete an assessment of their performance, health or knowledge of the English language, the time needed to complete the assessment, and/or

d the amount of time the parties will reasonably need to prepare for a review of whether the doctor continues to pose a current and ongoing risk to public protection requiring restrictive action in response or is safe to return to unrestricted practice.'

169. The Tribunal considered that a short period of suspension would not adequately mark the gravity of the conduct, nor send a message that such behaviour was unacceptable. The Tribunal did not see any reason to depart from the sanctions banding identified in the Guidance.

170. The Tribunal acknowledged that any period of suspension would undoubtedly have an impact on Dr Dimitriadis. However, it was of the view that this was outweighed by the need to uphold professional standards and send out a signal to Dr Dimitriadis, the public and the profession that his behaviour was unacceptable.

171. The Tribunal was of the view that Dr Dimitriadis needed sufficient time to address the concerns of the Tribunal and complete his remediation. For that reason, it considered that a period of suspension at the lower end of the sanctions banding would be the most appropriate. The Tribunal did not view that the maximum length available was necessary in the circumstances of this case.

172. The Tribunal concluded that a period of suspension for six months was the appropriate and proportionate response. This period reflects the seriousness of both Dr Dimitriadis's misconduct but also acknowledges the positive steps he has made, and the time he needs to complete further remediation.

Review

173. The Tribunal determined to direct a review of Dr Dimitriadis's case. A review hearing will convene shortly before the end of the period of suspension. The Tribunal wishes to clarify that, at the review hearing, the onus will be on Dr Dimitriadis to demonstrate to the review Tribunal's satisfaction how he has further developed his insight and remediated his misconduct. It therefore may assist the reviewing Tribunal if Dr Dimitriadis provides evidence of:

- his developed insight into the underlying cause of his misconduct.
- his remediation efforts, including any relevant CPD or training.
- how he has kept his knowledge and skills up to date during his suspension.
- to provide any other information that he considers will assist.

Determination on Immediate Order - 22/07/2026

174. Having determined that Dr Dimitriadis's registration be suspended, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Dimitriadis's registration should be subject to an immediate order.

Submissions

175. On behalf of the GMC, Ms Fairley submitted that the Guidance indicates, at paragraph 83, that the Tribunal should consider the seriousness of the proved allegations and the level of the current and ongoing risk to public protection when deciding whether to impose an immediate order.

176. She further submitted that paragraph 84(c) of the Guidance was engaged in this case. Ms Fairley submitted that an immediate order was necessary to maintain public confidence in the medical profession. Given the seriousness of the allegations found proved, she submitted that immediate action was required to uphold public confidence pending the coming into effect of the substantive sanction.

177. On behalf of Dr Dimitriadis, Mr Lownds did not make any submissions in relation to the imposition of an immediate order.

The Tribunal's Determination

178. The Tribunal considered that it may impose an immediate order if it considers it necessary for the protection of members of the public or is otherwise in the public interest.

179. The Tribunal had regard to the relevant paragraphs of the Guidance, in particular paragraphs 83 and 84, which set out:

> *"83. The decision whether to impose an immediate order is at the discretion of the MPT based on the facts of the case. When deciding if an immediate order is needed the MPT should consider the seriousness of the proved allegation and the level of current and ongoing risk to public protection posed by the doctor.*

84 It will not usually be appropriate for a doctor to hold unrestricted registration until a sanction takes effect in cases where:

a. the doctor poses a risk to patient safety
b. the risk to one or more parts of public protection is high, and/or

immediate action is needed to maintain public confidence in the medical profession

c. immediate action is needed to maintain public confidence in the medical profession."

180. The Tribunal has borne in mind its findings about the risk to public protection, public confidence and professional standards in this case.

181. Therefore the Tribunal determined that it is necessary for the protection of members of the public and is in the public interest to suspend Dr Dimitriadis's registration forthwith.

182. The Tribunal therefore determined that an immediate order was necessary in the circumstances of this case.

183. This means that Dr Dimitriadis's registration will be suspended 28 days from the date on which written notification of this decision is deemed to have been served, unless he lodges an appeal. If Dr Dimitriadis does lodge an appeal, he will not be free to practise unrestricted until the outcome of any appeal is known.

184. The Tribunal revoked the interim order.

185. That concludes this case.