

**PUBLIC RECORD**

**Dates:** 16/03/2026 - 27/03/2026  
19/05/2026 - 21/05/2026

**Doctor:** Dr Andreas PRACHALIAS

**GMC reference number:** 4153593

**Primary medical qualification:** Ptychio Iatrikes 1990 University of Crete

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

**Summary of outcome**

Suspension, 12 months  
Review hearing directed  
Immediate order imposed

**Tribunal:**

Legally Qualified Chair	Mr Gul Nawaz Hussain
Lay Tribunal Member:	Mr Darren Shenton
Registrant Tribunal Member:	Dr Juliet Bennett
Tribunal Clerk:	Mr Larry Millea

**Attendance and Representation:**

Doctor:	Present, represented
Doctor's Representative:	Mr David Morris, Counsel, instructed by Kingsley Napley
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 public.

## 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 - 23/03/2026

### Background

1. Dr Prachalias qualified as a doctor in 1990. Prior to the events which are the subject of the hearing, Dr Prachalias practised in Greece until 1997 and in 2000 completed a fellowship at the Liver Unit ('the Unit') of King's College Hospital NHS Foundation Trust ('the Trust'). Following this, he returned to Greece and worked as a Consultant Surgeon.
2. Dr Prachalias returned to London in 2004 and began working at the Trust in a locum consultant position in HPB (Hepato-Pancreato-Biliary) and liver transplantation. In 2006, his locum post converted to a substantive consultant post, in 2011 he was appointed Clinical Governance Lead for liver work, and in 2012 was appointed Lead Clinician for HPB surgery. Between 2011 and 2019, Dr Prachalias was also Lead for Risk and Governance at the Unit. In November 2018, he was appointed Clinical Director for the Liver Care Group at the Trust and commenced the role in January 2019. In November 2020, he was re-appointed as Clinical Director of the newly formed Care Group of Liver, Gastroenterology and Endoscopy, a role he held until September 2023.
3. At the time of the events, Dr Prachalias was practising as a Consultant Hepatologist at the King's College Hospital ('the Hospital') in London and Clinical Director of the Institute of Liver Studies.
4. The allegations that have led to Dr Prachalias' hearing relate to his conduct. It is alleged by the General Medical Council (GMC) that, in or around late 2020 or early 2021, Dr

Prachalias behaved in a way which was intimidating towards Dr A and on 1 January 2021 made intimidating comments in relation to other staff members. It is also alleged that, on 10 December 2021 at a work Christmas party, Dr Prachalias behaved in a way towards Dr B which constituted sexual harassment, was sexually motivated and was an abuse of his more senior position. It is further alleged that, on 14 June 2022, Dr Prachalias' conduct towards Dr C amounted to direct discrimination.

### The Outcome of Applications made during the Facts Stage

5. The Tribunal granted the GMC's application, made pursuant to Rule 35(4) and Rule 36(1) of the GMC (Fitness to Practise Rules) 2004 as amended ('the Rules'), for Dr B to be anonymised throughout proceedings. The Tribunal's full decision on the application is included at Annex A.

### The Allegation and the Doctor's Response

6. The Allegation made against Dr Prachalias is as follows:

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

1. In or around late 2020 or early 2021, you attended a work meeting about a bed crisis after which you:
  - a. pushed open the door to Dr A's office so hard that the door hit the wall; **To be determined**
  - b. said to Dr A 'Dr A get the fuckers out', or words to that effect to which you were referring to patients and then walked out. **To be determined**
2. On 1 January 2021, Dr A was explaining to you why the junior doctors were not in, and you said "Get the fuckers in" or words to that effect and then stormed off. **To be determined**
3. Your conduct at paragraphs 1-2 was intimidating. **To be determined**
4. On 10 December 2021, at a work Christmas party:
  - a. Dr B went to the bar to order a drink when you:

- i. looked at Dr B up and down; **To be determined**
    - ii. grabbed Dr B's belt and pulled her towards you; **To be determined**
    - iii. whispered to Dr B in her ear "why don't you dress like that more often", or words to that effect; **To be determined**
  - b. you came up behind and leant into Dr B whilst she was dancing and said "more, more", or words to that effect. **To be determined**
5. On 14 June 2022, Dr C attended your office for a meeting, and you said to her "Can you just go off and wait in the other room while I tell these two [Dr D and Dr E] a dirty man joke" or words to that effect. **Admitted and found proved**
6. Your actions as set out at paragraph 4:
- a. constituted sexual harassment as defined in Section 26(2) of the Equality Act 2010, in that you engaged in unwanted conduct of a sexual nature which had the purpose or effect of violating the dignity of Dr B, or creating an intimidating, hostile, degrading, humiliating or offensive environment for Dr B; **To be determined**
  - b. were sexually motivated; **To be determined**
  - c. were an abuse of your more senior position. **To be determined**
7. Your conduct at paragraph 5 amounted to direct discrimination in that because of Dr C's protected characteristic namely sex, you treated Dr C less favourably than you treated or would have treated others as defined in Section 13 of the Equality Act 2010. **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

7. At the outset of these proceedings, through his Counsel, Mr Morris, Dr Prachalias made admissions to some 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 and sub-paragraphs of the Allegation as admitted and found proved.

### Witness Evidence

8. The Tribunal received oral evidence on behalf of the GMC from the following witnesses:

- Dr A, Professor of Hepatology and Chronic Liver Failure at the Hospital, in person on 16 March 2026. Their witness statement was dated 13 March 2024;
- Dr B, XXX at the Hospital at the time of the alleged events, in person on 16 March 2026. Their witness statement was dated 11 March 2024.

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

- Dr D, Consultant Hepatologist at the Hospital. Their witness statement was dated 14 February 2024;
- Ms F, Senior Service Manager at the Hospital at the time of events. Their witness statement was dated 14 March 2024.

10. Dr Prachalias provided his own witness statement dated 4 January 2026 and also gave oral evidence at the hearing.

11. In addition, the Tribunal received evidence from the following witnesses on Dr Prachalias' behalf:

- Dr G, Dr Prachalias' wife and Consultant Radiologist at Princess Royal University Hospital (part of King's College NHS Foundation Trust), Her witness statement was dated 27 January 2026 and she was called to give evidence in person on 17 March 2026;

- Ms H, HPB Clinical Nurse Specialist at the Hospital. Her witness statement was dated 5 January 2026 and she was called to give evidence in person on 17 March 2026;
- Dr I, Consultant Hepatobiliary, Pancreatic and Liver Transplant Surgeon at the Hospital. His witness statement was dated 4 January 2026 and he was called to give evidence in person on 17 March 2026;
- Dr J, Consultant Hepatologist at the Hospital. His witness statement was dated 15 March 2026 and he was called to give evidence in person on 18 March 2026;
- Dr L, Consultant Liver Transplant and HPB Surgeon at the Hospital, His witness statement was dated 16 March 2026 and he was called to give evidence in person on 18 March 2026.

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

- Ms K, HPB Clinical Nurse Specialist at the Hospital. Her witness statement was dated 23 January 2026.

### Documentary Evidence

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

- Trust Investigation Meeting Notes for Dr A, Dr D, Ms F, Ms K, various dates late 2022/early 2023;
- Text message from Dr D to Ms F, dated 14 June 2022
- Text message from Dr D to Ms F, dated 20 June 2022
- Message from Dr A to Dr Prachalias, dated November 2021.

### The Tribunal's Approach

14. In reaching its decision on the facts, the Tribunal should apply the civil standard of proof. This means that the Tribunal must decide whether, on the balance of probabilities, the GMC is able to prove it is more likely than not that the matters occurred as alleged. The burden of proof rests with the GMC and it is for the GMC to prove the case that it is presenting against the doctor. There is no burden on the doctor to prove or disprove anything.

15. The Tribunal should approach fact finding by firstly identifying agreed facts and evidence. To reach a decision on the disputed facts, the Tribunal will assess the evidence in the round. It will consider what conclusions and inferences can be drawn from the documentary evidence. The Tribunal will then consider the available oral evidence and subject that evidence to critical scrutiny against the agreed facts and documentary evidence to consider a witness' reliability and credibility. The Tribunal should not decide reliability and credibility based on the demeanour of a witness alone.

16. Dr Prachalias had no record of disciplinary or regulatory findings against him. The Tribunal was reminded that good character cannot of itself amount to a defence to allegations. However, it is evidence that can be taken to account in the following ways. Firstly, it goes to the credibility of the witness. Secondly, it may mean he is less likely to have acted as alleged. It is for the Tribunal to decide what weight it should give to these matters. This had to be considered in light of Dr Prachalias' admitted misconduct in this case.

17. The Guidance for MPTS Tribunals ('the Guidance') states that:

*Good character is not a defence to the facts alleged. However, the MPT must take good character evidence into account in their assessment of a witness' credibility and propensity, where relevant. The assessment of whether a witness is of good character is made on the balance of probabilities, having considered all available information about the witness' character. The weight to be given to a witness' good character is a matter for the MPT and should be explained in their written determination. The MPT may consider that the weight given to an unblemished record may properly be less in the case of a doctor at an early stage in their career than a doctor with an established track record.*

18. This case involves sexual motivation and sexual harassment. The Tribunal is therefore cautioned against applying stereotyped images of how an alleged victim or an alleged perpetrator of an allegation of this nature ought to have behaved at the time, or ought to appear while giving evidence. Instead, the Tribunal is to judge the evidence on its merits and should note for example that:

- a. People react differently to behaviour of this sort;
- b. Some may complain immediately whilst others feel shame and shock and do not complain for some time;

c. A timely complaint is not necessarily true just because it was made immediately just as a late complaint does not necessarily mean it is a false complaint.

19. The term ‘sexually motivated’ is defined in the case of *Basson v GMC [2018] EWHC 505* as: ‘A sexual motive means that the conduct was done either in pursuit of sexual gratification or in pursuit of a future sexual relationship’. The Tribunal must be satisfied on the evidence that there was a specific intent. Sexually motivated conduct is not the same as carelessness, recklessness or negligence.

20. The Tribunal must consider if there is a plausible alternative explanation before determining if the conduct was sexually motivated.

21. Sexual Harassment is defined at section 26(2) of the Equality Act 2010 which is set out in the Allegation:

*“that you engaged in unwanted conduct of a sexual nature which had the purpose or effect of violating the dignity of, or creating an intimidating, hostile, degrading, humiliating or offensive environment”*

22. In cases of harassment pleaded with reference to the Equality Act, harassment can be made out where there is a single instance of conduct.

23. In cases of sexual harassment it is no less sexual harassment simply because the registrant had no intention to take matters further.

### **The Tribunal’s Analysis of the Evidence and Findings**

24. The Tribunal has considered each outstanding paragraph of the Allegation separately and has evaluated the evidence to make its findings on the facts.

#### Background

25. The Tribunal considered the circumstances and context of the Allegation, namely the working environment and culture at the Hospital and, more specifically, the Unit.

26. The Tribunal heard evidence from both GMC and defence witnesses as to the cultural challenges and difficult working environment at the Unit before and around the time of the alleged events.

27. In her witness statement Dr A describes:

*“I began to experience certain behaviours from Andreas once he took over as the Clinical Director of the Institute of Liver Studies. I think this was late October 2018.*

*My observations and concerns regarding Andreas arose at this point when he became Clinical Director.*

*My concerns were mainly around the way Andreas was leading the department. At the time it was a very male dominated department with about 90% of my colleagues being male.*

...

*As a female consultant, I found it difficult to work in that environment.”*

28. During her oral evidence Dr A described how she grew up in a culture in the Unit where it was not unusual for uncomfortable language and derogatory language to be used in conversations or in relation to trainees and that she became hardened to people talking in that way. She said that there were issues around culture in the department, but also more widely in the Trust, and that it was increasingly difficult for everybody to work in that environment. She stated that she felt that this got worse and culminated around the time of the alleged events, but that it was a broader culture in the Unit and that there were many other individuals who contributed to the toxic culture, which pre-existed Dr Prachalias’ appointment.

29. In his GMC witness statement, Dr Prachalias states that:

*“It is important for the Panel to understand the culture within the Unit, and its potential relevance to the charges against me.*

...

*I was Clinical Director of the Unit between 2019 and 2023, which meant that I was responsible for the overall function and performance of all the Unit’s workstreams. As*

*Clinical Director, I oversaw the quality of the clinical, educational and research work through the framework of Clinical Governance. The role was demanding; particularly during the COVID-19 pandemic, where I had to adapt the Unit's functions in order to respond to the unprecedented health pressures of the population. Under my leadership, the Unit had excellent outcomes."*

30. When Dr Prachalias was asked whether he accepted Dr A's description of the culture at the Unit before his appointment as Clinical Director as a 'boys club' where there was use of profanity and the behaviour of the men was challenging for her and for others, he agreed.

31. Dr Prachalias went on to state that his predecessor resigned, partly as a result of that culture and the undermining that he felt he was receiving. He was appointed as Clinical Director and was given a mandate by the Trust to change what was perceived to be the major issue of the problematic culture and stagnation in leadership which had occurred over several years. Dr Prachalias described how a whole restructure of the Unit took place, where all existing leads resigned and, following a competitive process where the previous leads also could apply, new leads and new forms of subgroups within the care group were established, just prior to the Covid pandemic.

32. Dr Prachalias explained to the Tribunal that problems with junior doctors' attendance were constant because junior doctors were either getting COVID or they had been exposed to COVID and they had to follow isolation policies, so the junior doctor shortages were 'universal' and were underpinning the difficulties in delivering care at that time.

33. When asked whether he agreed with Dr A's account that the culture at the Unit had got worse under his tenure, Dr Prachalias stated that was very subjective and that the Unit performed better than any other unit in the country during Covid, which was something that has been recognised nationally and celebrated by the Trust, so if a culture had been problematic and got worse that would have hampered the Unit and its performance.

34. In his GMC witness statement, Dr I stated that:

*"The Unit is a very specialised department. Our work is complex and high-pressured, given we care for patients with liver disease at a tertiary level. We are also exceptionally busy. I work both in the Liver Transplant and HPB service."*

35. Dr I also gave oral evidence in relation to the culture at the Unit, stating that Dr Prachalias tried his very best to address the culture at the Unit when he was Clinical Director by changing the system, the leads within the Unit, and the work ethos and culture. He stated that in spite of working so hard and doing everything that needed to be done to get the Unit back on track it did not happen and “*clearly it's resulted in this*” which was the start of the “*break*” of the Unit, seemingly referring to the allegations against Dr Prachalias.

36. Dr I stated that he thought that there was a ‘break’ in the sense that the interpersonal relationship between people had slowly disintegrated for the last few years and continues to do so to a certain degree. He stated that it was very stressful during Covid due to both staffing difficulties and the number of beds occupied by Covid patients. He went on to describe how successful the Unit was, both in terms of the surgeries and specialist services performed there and its performance during Covid, and how this led to some jealousy and resentment, both from within the Unit and from outside the Unit.

37. When asked how long he had worked with Dr A for, Dr I stated:

*“[Dr A] is more of an academic rather than a clinician who works on the floors. I know she's more entwined with the medical school and I think she probably does an on-call once every eight or 10 weeks.*

*...for about 20 years, but I work with her in the sense she is a, as far as I know, she does not do transplants, so she does not look after post-transplant patients. She is not involved in hepatobiliary and pancreatic surgery.*

...

*She's not a surgeon, so I wouldn't see her in the operating theatre. But she's not somebody whom I would call as a regular work colleague, because, as I said, I do liver transplantation and HPB surgery. She's a clinician who works on faecal biomes so our interests are very different. Yes, she is aligned to the liver unit, but the liver unit at King's is predominantly liver transplantation and HPV surgery and complex hepatology and she works in a subspecialty of hepatology so therefore, we don't really see each other.”*

38. When asked if he considered Dr A to be a part of the team/the Unit, Dr I answered “No”.

39. The Tribunal considered that Dr I's comments highlighted the hierarchical and at times fractured culture at the Unit described by multiple witnesses.

40. Ms H, HPB Clinical Nurse Specialist at the Hospital described Dr Prachalias as among the best Consultants she had worked with and that as a colleague he was understanding, caring and compassionate. When it was put to her during her oral evidence that Dr Prachalias had told a rude joke and she was asked whether she was surprised by this she stated *"Yeah, probably a little bit"*. When it was explained to her that Dr Prachalias excluded a female colleague from a meeting Ms H suggested that there must have been a reason for this. When it was explained to her that Dr Prachalias had accepted that it was wrong for him to do so and whether she was surprised by that, Ms H replied that *"nothing really surprises you nowadays, isn't it so?"*

41. The Tribunal found these answers surprising. Ms H was quick to dismiss facts (accepted by Dr Prachalias) which were at clear odds with the evidence she had given. The Tribunal was of the view that her approach and evidence were indicative of the hierarchical structure of the Unit and her perception of and place within it.

42. The Tribunal noted that Dr Prachalias admitted paragraphs 5 and 7 of the Allegation, and in his GMC witness statement stated of the event:

*"I admit this allegation. To provide further context, before a meeting, Dr D entered my office, placed a document on my desk, and said, 'sign this,' without any explanation. In response, I made a joke that was inappropriate for the setting. The joke was something that my father had written to me in a letter when I was a young medical student [XXX]. My father had written that men were prone to making two serious errors in life: signing a document without knowing its contents and putting their penis in an unknown place. I repeated this joke to Dr D and Dr E. I said 'dot dot dot' as part of the joke, rather than using the word penis. My intention was to highlight that asking for a signature without explanation is not appropriate, but I recognise that the way I expressed this was ill-judged.*

*Before telling the joke, Dr C came to the door of my office, and I asked her to wait outside whilst I told Dr D and Dr E the joke. At the time, I felt that this was an appropriate and respectful thing to do, so as not to tell the joke in front of a woman, but I now understand that this was not the correct approach to take.*

*When this matter was brought to my attention, I apologised to Dr C as soon as possible after learning that she was upset. I offered to put my apology in writing to Dr C, to which she stated that this was not necessary. I also apologised to {Dr D}.*

...

*At the time, I was operating under what I assumed to be Dr C's best interest but, it is now clear to me that in excluding Dr C, I was unintentionally discriminating against her.*

*Dr C was never excluded from any material professional discussions as a result of this. She was only excluded from the joke that I told which, I accept, should not have been told. This was a one-off incident that I have learned from and will never repeat."*

43. In his GMC witness statement, [Dr D] stated of this incident:

*"[Dr C] had barely got through the door when this happened. She appeared surprised and shocked as she opened the door to be told this. Andreas waved his hand for her to leave his office and told her to wait for us in the meeting room. I have been asked by the GMC what the "dirty man joke" is that Andreas told. To confirm, I honestly cannot remember.*

...

*On page 2 of Exhibit VP1 [Dr D's Trust investigation meeting notes] I make reference to discussing the meeting with [Ms F]. She is the General Manager of the Liver Unit at Kings. She is equivalent to Andreas in the divisional structure. I recounted to [Ms F] how [Dr C] was treated and said I was upset by it as was [Dr C]. I provided her with a verbal account only.*

*On page three of Exhibit VP1 [Dr D's Trust investigation meeting notes] I talk about Dr Prachalias "barking" at the meeting with [Dr C]. This was the same meeting referred to earlier. [Dr C] was the Clinical Lead at the time. Andreas, by virtue of his position as Clinical Director, was required to provide input into that meeting. The meeting itself did not achieve what was required. We were putting to him legitimate concerns about the impact in loss of manpower on the service in question, and we were trying to*

*suggest potential options and solutions. He remarked “there is no solution to this”. It was clear during that meeting that Andreas had lost engagement from [Dr C], and I think the way he treated her earlier contributed in a large part to this. I was upset by seeing the effect it had had on her, and I felt guilty for not calling it out at the time. To clarify, Andreas was combative in the way he spoke to us all and was not constructive. We held that meeting to help senior management understand the issues we were facing, and consider potential solutions. What [Dr C] and I were looking for was an acknowledgement of the concerns, and instead these were trivialised. He did not understand the gap left by the colleague that had left, that this gap would be difficult to fill, or the risk to the patients and service, and that we needed a meaningful and viable approach to finding a solution, even if this would take time.*

*At the bottom of Exhibit VP1 I make reference to [Ms F] speaking with Andreas. I think when I checked in with [Ms F] she said she had briefly addressed the issue with [Dr C] that I had raised to Andreas and explained to him that this behaviour was not appropriate. [Ms F] fed back that Andreas explained it away as being Greek and said “it is just me” and “I was just having a joke”. He apparently did not think what he had done was inappropriate or required an apology to [Dr C]. My concern was I was raising legitimate concerns about a colleague being mistreated and was clearly upset by this, and the response appeared to be “I am not the problem” and a form of gaslighting.”*

44. The Tribunal also had regard to WhatsApp messages between Dr D and Ms F, which include the following discussion around the events in relation to paragraph 5 of the Allegation.

45. On 14 June 2022, Dr D texted:

*“I know it’s late [Ms F], but need to let you know that before you arrived, Andreas treated [Dr C] completely inappropriately.*

*I was caught totally unaware and should have called it out at the time but it’s only just hit me.*

*I’ve messaged [Dr C] to say sorry and she’s understandably upset.*

*Can we chat tmrw pls. I’m totally done with this crap”*

46. On 22 June 2022, in response to a query from Dr D as to how the discussion with Dr Prachalias went, [Ms F] messaged:

*“Hey it went well we spoke today. I have an email to send [Dr C] and he agreed to speak to her and apologise*

*He also felt that you should feel free to come to him and tell him when he is acting in a way that is not correct*

*....I think he is more open to hearing this feedback now*

*And genuinely was like I totally wasn't trying to offend her at all*

*And was a bit shocked that his actions had come across that way*

*So it's a positive step*

*Me thinks he was very sheltered from the truth  
Before*

*I was glad that he didn't flip out at all*

*He just said he would speak to you both*

*But said that you both should just tell him  
If you ever feel this way again*

*That way he will know*

*[facepalm emoji]*

*Baby steps I guess*

*...”*

47. The Tribunal also considered the GMC witness statement of Dr B, as set out below, where she stated that she had observed Dr Prachalias shouting at other people:

*“I have been asked by the GMC if I ever experienced inappropriate behaviour from Mr Prachalias. At the beginning, meaning when I started working at King’s, it is hard, as you need to get use to a new system - you don’t open your mouth, you work and do your job. Mr Prachalias had his ways of doing things – I’m not saying that it is right – but I’m [XXX], and in [XXX], consultants are tough, and they shout – it is something that I’ve been raised with. I appreciate that others might not think that is ok, but it is typical of consultants I’ve worked with. Mr Prachalias liked to show that he was there, to show his authority. I can say that he never shouted at me (he has not), but I have seen how he has treated other colleagues and it is not nice. I saw him shout at other people, for example if the assistant wouldn’t help him in the way he wanted, he would shout...”*

48. In considering the Allegation, the Tribunal was therefore mindful of the historic cultural difficulties and challenging work environment at the Unit prior to Dr Prachalias’ appointment, as well as the varying accounts of how Dr Prachalias engaged with, and participated in, this culture during his tenure.

49. In doing so, the Tribunal acknowledged that there was immense pressure at the Unit and in medical practice generally due to the Covid pandemic, creating extraordinary, unprecedented pressures.

#### Paragraph 1

50. Having set out the background and circumstances at the Hospital at the time of events, the Tribunal then went on to consider sub-paragraphs 1(a) and 1(b) of the Allegation, namely that Dr Prachalias pushed open the door to Dr A’s office so hard that the door hit the wall, and said to Dr A ‘Dr A get the fuckers out’, or words to that effect to which he was referring to patients, and then walked out.

51. Dr Prachalias denied this allegation, stating in his GMC witness statement:

*“I have no recollection of any such incident. I attended many bed crisis meetings during the pandemic and cannot know which meeting this allegation is said to refer to.*

*I cannot recall using the word ‘fuckers’ in conversation with Dr A or any other member of staff at the Trust. Generally, I do not communicate with expletives, as a result of my*

*traditional Greek upbringing which required my adherence to codes of behaviour from both a cultural and religious standpoint. Therefore, whilst I have used expletives at times, it is a rarity. I can certainly never recall using this word with Dr A. Moreover, I do not recall ever using any expletive to describe patients. They are the foundation of my work, and every step of my career has been dedicated to safeguarding their well-being.”*

52. In her GMC witness statement, Dr A described the event as follows:

*“I did often feel intimidated by Andreas. He would often shout and scream and easily lost his temper. On one occasion, after attending a meeting about a bed crisis, he pushed open the door to my office so hard the door hit the wall. He said to me, ‘[Dr A] get the fuckers out’ and walked out. By this I believe he was referring to patients as I was the duty consultant hepatologist. I understand he was stressed, and he’d probably just had someone shout at him, but it’s very difficult to work in an environment when people are acting like that. I can’t recall when this took place, but I think it was likely late 2020 or early 2021. I was taken aback and had no chance to respond before he left.”*

53. The Tribunal was of the opinion that Dr A was measured and fair in the way she gave evidence, acknowledging how well she had got on with Dr Prachalias prior to his appointment as Clinical Director and had no previous issues with inappropriate behaviour by him. She contextualised the event and acknowledged that Dr Prachalias was likely experiencing stress and *“probably just had someone shout at him.”*

54. During her oral evidence, Dr A stated:

*“I would very much reiterate that. I worked, I’ve been working at King’s since September 2006 and I had a very good working relationship with him when I started in September 2006 up until about 2018 and things started to get very difficult for me personally when he became clinical director, because I felt very much that he was no longer that supportive colleague that he used to be.”*

55. The Tribunal considered that Dr A was consistent and credible in her account, throughout the Trust investigation meeting, her GMC witness statement and her oral evidence to the Tribunal, even when challenged. She gave evidence about toxicity in the

culture of the Unit which was corroborated by other witnesses including those who gave evidence in support of Dr Prachalias, and indeed Dr Prachalias himself.

56. It was put to Dr A that had the events occurred as she described, and she had felt intimidated, why did she subsequently WhatsApp message Dr Prachalias asking for assistance with XXX. Dr A responded that the WhatsApp conversation, which the Tribunal had sight of, followed a corridor conversation and a formal e-mail to the department making them aware that XXX was unwell and in hospital, which was impacting her ability to fulfil her clinical duties. Dr A stated that whilst she was very indebted to Dr Prachalias and his wife for helping in that situation, it was also allowing and enabling her to return to work, and so the exchange should be viewed in the context of a professional conversation.

57. Overall, the Tribunal considered Dr A to be a credible witness who provided a consistent account, and that she had no reason to fabricate such events.

58. Dr Prachalias stated in his oral evidence that he had always had and maintains *“measured and calm behaviour in addressing people and issues in meetings.”* However, the Tribunal had received evidence from multiple witnesses that this was not always the case. Additionally, Dr Prachalias accepted acting inappropriately on at least one occasion, with Dr C, and the evidence was that he was not aware of his inappropriate conduct or its effect on his colleagues at the time.

59. Whilst the evidence of Dr Prachalias’ wife was that he would not ordinarily swear, the Tribunal considered that the circumstances at the Unit were out of the ordinary and exceptionally stressful, and that this did not preclude the possibility that Dr Prachalias had sworn under the circumstances.

60. Overall, the Tribunal preferred the evidence of Dr A and concluded that, on the balance of probabilities, Dr Prachalias had spoken and acted as alleged.

61. In doing so, the Tribunal noted that he used those terms in a specific, indirect context and his words were not directed at any individuals.

62. Accordingly, the Tribunal found paragraph 1 of the Allegation proved.

## Paragraph 2

63. The Tribunal next considered paragraph 2 of the Allegation, namely that while Dr A was explaining to Dr Prachalias why the junior doctors were not in, he said ‘Get the fuckers in’ or words to that effect and then stormed off.

64. In his GMC witness statement, Dr Prachalias states:

*“I have no recollection of this conversation with Dr A. As above, I do not recall using this type of language and it would be unusual for me to do so, particularly regarding junior doctors during the pandemic as I appreciated how we were completely reliant on them for the continuing function of the Unit.”*

65. In her GMC witness statement, Dr A stated:

*“I was Training and Education lead and rota lead for the junior doctors and there were days when we had no junior doctors turning up to work as they were all sick with covid and/or isolating at home. Andreas dealt with that very badly - he put a lot of pressure on me to just call round staff and get them into work. He talked about junior colleagues in derogatory ways – he would frequently refer to them as ‘fuckers’. On New Year’s Day 2021 he used this expression when he spoke with me and [Dr E] outside the entrance to the Institute of Liver Studies when we were discussing how we could not safely staff the department. You don’t expect that from the Clinical Director when you’re having a serious conversation about dangerously poor staffing levels.”*

66. Dr A’s GMC witness statement was consistent with her earlier Trust Investigation meeting notes and her oral evidence to the Tribunal.

67. For the same reasons as set out in relation to paragraph 1 of the Allegation, namely the consistency and credibility of Dr A’s account, the Tribunal accepted the account of Dr A and concluded that, on the balance of probabilities, Dr Prachalias had acted and spoken in the manner alleged.

68. Accordingly, the Tribunal found paragraph 2 of the Allegation proved.

### Paragraph 3

69. The Tribunal went on to consider paragraph 3 of the Allegation, that Dr Prachalias’ conduct at paragraphs 1-2 was intimidating.

70. The submission made on behalf of Dr Prachalias was that it was accepted that Dr A's description of his behaviour would amount to intimidation in respect of paragraph 2 of the Allegation, as Dr A expressly describes being intimidated that day in the Trust investigation meeting of 31 October 2022.

71. However, Mr Morris, on behalf of Dr Prachalias, submitted that in respect of paragraph 1 of the Allegation, Dr A stated that she was not intimidated by the language and did not feel frightened or threatened by Dr Prachalias' behaviour.

72. The submissions made on behalf of the GMC were that it was not alleged that Dr Prachalias' behaviour was "*frightening*" or "*threatening*" but that the act of "*intimidating*" someone is literally to make them timid or to scare them, which is precisely what Dr A described.

73. In her GMC witness statement, Dr A stated that: "*I did often feel intimidated by Andreas. He would often shout and scream and easily lost his temper.*"

74. In Dr A's Trust investigation meeting she stated that: "*Andreas can be a very intimidating person. If he wants to talk to you he won't knock on the door, he'll just barge into your office.*" and in respect of the incident of 1 January 2021 stated: "*I was in a corridor, trying to explain to Andreas why the juniors weren't in and he said, "Get the fuckers in", and then stormed off. But I couldn't get the junior doctors in, because they had COVID. I was very intimidated that day.*"

75. Throughout her oral evidence Dr A reiterated that she had felt intimidated by Dr Prachalias' behaviour. She stated that it was not the language she found particularly intimidating, although she found it derogatory and insulting to colleagues and patients, but that she actually often felt intimidated in situations where a male colleague, in this case Dr Prachalias, 'loses their rag' or gets very angry, and that this is very intimidating and made her afraid.

76. The Tribunal also considered the witness statement of Dr B, as set out above, where she stated that she had observed Dr Prachalias shouting at other people and Dr D's evidence that Dr Prachalias would speak to colleagues in a "*combative*" manner.

77. The Tribunal was satisfied that Dr A had found Dr Prachalias' behaviour intimidating and was consistent on this point throughout her evidence to the Trust and for these proceedings. Further, it considered that Dr Prachalias' behaviour, as found proved in respect of paragraphs 1 and 2 of the Allegation, was objectively intimidating and it was reasonable for Dr A to find his actions and behaviour intimidating.

78. Accordingly, the Tribunal found paragraph 3 of the Allegation proved.

#### Paragraph 4

##### 4(a)

79. The Tribunal went on to consider paragraph 4(a) of the Allegation, that on 10 December 2021, at a work Christmas party Dr B went to the bar to order a drink when Dr Prachalias looked at Dr B up and down, grabbed Dr B's belt and pulled her towards him and whispered to Dr B in her ear "why don't you dress like that more often", or words to that effect

80. Dr Prachalias denied this paragraph of the Allegation and stated in his GMC witness statement that:

*"I may have spoken with Dr B briefly, but I do not have any recollection of having a conversation with her, given the time that has passed. I did not dance during the party, and therefore I do not recall being in the vicinity of where others were dancing. Generally, I do not dance at social events, as I am admittedly not good at it, and prefer to refrain. I left the party with [Dr I] at approximately 10pm - 10.30pm. When we were leaving, [Dr B] and [Person M] from my team tried to grab us and pull us to dance with them. [Dr I] and I refused and left the pub."*

81. The submission made on Dr Prachalias' behalf was that had the events occurred as described by Dr B, other people at the party would have noticed, given that it was a busy pub. Mr Morris submitted that "It may have been over in a matter of seconds but it wasn't surreptitious or covert. This was sexual harassment in plain sight."

82. Mr Morris submitted that this incident was investigated by the Trust and later by the GMC and yet they have not been able to disclose any independent evidence confirming Dr

B's account. He invited the Tribunal to consider how realistic it was for Dr Prachalias to have acted in such a reckless way under the circumstances.

83. The Tribunal considered that Dr Prachalias denied the allegation and did not suggest that he acted in any way which could have been misinterpreted. As such, the Tribunal considered whether Dr B had fabricated or imagined the events she described.

84. The Tribunal noted that Dr Prachalias was of previously good character, but that this was caveated by his admission to paragraphs 5 and 7 of the Allegation. On that occasion, Dr Prachalias had acted inappropriately and in a discriminatory fashion towards a junior female colleague.

85. The Tribunal considered the description of events given by Dr B, as set out in her GMC witness statement:

*"I can recall an incident that occurred at the Christmas party. I had just arrived at the party and there were a lot of people there. I went to the bar to order a drink and Andreas was there. He looked me up and down, then he grabbed me from my belt, and pulled me towards him. We were standing close to each other before he grabbed my belt, so he didn't have to pull hard. He whispered in my ear – 'why don't you dress like that more often?' What I think he meant by that was that I usually wear casual, loose-fitting clothing, or I'm usually in scrubs. For the party I wore tight jeans and a tight shirt and a belt. I was still at a work's party, so I was not dressed inappropriately. When Andreas said this, I was shocked; I don't think I even answered him – sometimes it's better not to answer. I cannot recall how long he held my belt; I don't know if he was still holding it or not when he started to whisper. I can't recall what I did, maybe I smiled and ordered my drink, I cannot recall. I walked away. I don't think there was anyone else at the bar at the time there to witness it."*

86. Dr B was consistent in her account during her oral evidence and under cross-examination. She described how following Dr Prachalias pulling her in they were still at a normal talking distance, but closer than before. The Tribunal considered it plausible that given the description of events as brief and relatively subtle, it would have been possible for this to have not been noticed by others during a party or raised concerns in a busy pub with lots of people standing in close proximity to one another.

87. Dr B's account was that she had discussed the incident with several colleagues, and raised it in her exit interview, as set out in her GMC witness statement:

*"I probably told [Mr N] and [Dr J] and [Dr L] about what happened. This was not as a formal complaint, but just in conversation. I hadn't thought about reporting it as I had [XXX] and then I started a new job. [Mr N] encouraged me to do an exit interview because it would be good as someone who had been there for four years to talk about my time there. I had a very good time at King's, but of course there were also some bad things. I left because I got a [XXX] job. The opportunity came up and I didn't want to wait for an opportunity at King's because I didn't know how long that would take."*

88. The colleagues in question had no recollection of Dr B raising the incident with them, and the Tribunal was not provided with a copy of Dr B's exit interview. However, the Tribunal accepted that she had an exit interview, which was not challenged, and concluded that she must have raised the incident with the Hospital or Trust at the time in order for it to have been escalated and formed part of the GMC investigation.

89. The Tribunal noted that Dr B did not actively pursue the allegations against Dr Prachalias. If she was lying this would have been for a reason; the most likely being to get him into trouble. The manner and nature of her reporting was not consistent with someone with such an animus. It was consistent with someone relaying a truthful account of something that had troubled them during an interview about their time at the hospital.

90. In his oral evidence, Dr J told the Tribunal that he had encountered Dr B ten days prior to the hearing XXX and she had raised the subject and said that she had been involved in this case, which was the first time he was aware that she was involved. The impression he got was she was considering whether she should go through this process or not, namely this Medical Practitioners Tribunal.

91. The Tribunal considered that this account, not contained in any of the statements and given orally by a witness for Dr Prachalias, was consistent with the view that Dr B was not lying to get Dr Prachalias into trouble; she had raised a genuine concern that she did not actively seek to escalate. This account supported Dr B's evidence that she was apprehensive and unsure how to deal with the situation and whether to escalate or pursue the allegations.

92. Dr B described how, in the circumstances of their professional relationship, she was shocked by Dr Prachalias' actions and did not know how to react. At the time Dr B did not

lodge or escalate a formal complaint, but stated that on reflection she felt that it was not right, discussed it informally with several colleagues and reported it in her exit interview.

93. In her oral evidence, Dr B stated that she was not gaining anything from this process other than the anxiety of having to relive the events and being able to move on.

94. The Tribunal considered that Dr B's account was consistent throughout and that she did not appear to embellish the events, which by her description were brief and limited. Dr B's account was credible, consistent and genuine, describing the events in a very matter of fact fashion.

95. The Tribunal considered that if Dr B was fabricating events against Dr Prachalias, those she described were lower on the spectrum of seriousness than might be expected.

96. Further, the Tribunal could identify no reason why Dr B would fabricate such allegations against Dr Prachalias. By her own account, Dr Prachalias was someone Dr B looked up to and he had supported her in obtaining a new XXX role, XXX.

97. The Tribunal determined that on the balance of probabilities, the events had occurred as described by Dr B.

98. Accordingly, the Tribunal found paragraph 3(a) of the Allegation proved.

#### 4(b)

99. Whilst the Tribunal accepted Dr B's account in relation to paragraph 4(a) of the Allegation and found that she had no reason to fabricate events, it considered the likelihood of paragraph 4(b) separately.

100. The Tribunal considered that the evidence taken at its highest was that Dr B did not see Dr Prachalias but heard his voice say two words, in a loud, busy environment with music, dancing and drinking.

101. The Tribunal accepted that Dr B genuinely believed that it was Dr Prachalias who said "*more, more*" to her, but could not be satisfied that under the circumstances, this was sufficient for Dr B to positively identify Dr Prachalias.

102. The Tribunal determined that the GMC had not discharged its burden of proof to the required standard and accordingly it found paragraph 4(b) of the Allegation not proved.

#### Paragraph 6

##### 6(a)

103. In considering this paragraph of the Allegation, the Tribunal reminded itself of the definition of sexual harassment in Section 26(2) of the Equality Act 2010, as set out in the Allegation, namely that Dr Prachalias engaged in unwanted conduct of a sexual nature which had the purpose or effect of violating the dignity of Dr B, or creating an intimidating, hostile, degrading, humiliating or offensive environment for Dr B.

104. The Tribunal considered that Dr Prachalias' actions towards Dr B as found proved amounted to unwanted conduct which was sexual in nature whereby he looked Dr B up and down, initiated unwanted physical contact, invading her personal space and whispering "*why don't you dress like that more often*" or words to that effect.

105. The Tribunal considered that this had the effect of violating the dignity of Dr B, or creating a degrading, humiliating or offensive environment for her, albeit it did not have an intimidating or hostile effect.

106. During her oral evidence, Dr B stated that she was shocked and felt that this was a violation of her personal space, describing how it caused her anxiety to relive the incident.

107. The Tribunal noted that Mr Morris submitted that the behaviour described "*was sexual harassment in plain sight*" and that in his GMC witness statement, Dr Prachalias agreed that such behaviour would amount to sexual misconduct.

108. Ms Fordham's submissions on behalf of the GMC were that this was certainly unwanted conduct and, in objectifying Dr B, it had the effect of violating her dignity.

109. In all the circumstances the Tribunal determined that Dr Prachalias' actions at paragraph 4(a) of the Allegation constituted sexual harassment and accordingly found paragraph 6(a) of the Allegation proved.

##### 6(b)

110. The Tribunal noted that sexual motivation can be defined as conduct that was done either in pursuit of sexual gratification or in pursuit of a future sexual relationship.

111. The Tribunal considered that there was no evidence or suggestion that Dr Prachalias, a married man, was seeking or pursuing a sexual relationship with Dr B, who was due to XXX. There was no evidence of previous or subsequent sexually motivated behaviour towards Dr B or other attempts to engage with her in a non-professional manner.

112. Accordingly, the Tribunal considered whether Dr Prachalias actions were carried out in pursuit of sexual gratification. In doing so it was mindful of the dictionary definition of “*gratification*” which is:

***noun***

*pleasure, especially when gained from the satisfaction of a desire.*

113. The Tribunal considered that Dr Prachalias grabbing Dr B’s belt and pulling her towards him did not sufficiently demonstrate sexual motivation when taken in isolation. It also considered that looking Dr B up and down did not necessarily demonstrate a sexual motivation in isolation, or when considered with grabbing her belt and pulling her towards him. The Tribunal considered that such behaviour towards a colleague, whilst inappropriate, could have motives other than sexual gratification.

114. However, the Tribunal concluded that Dr Prachalias also whispering “*why don’t you dress like that more often*” in Dr B’s ear contextualised his actions in looking her up and down, grabbing her belt and pulling her in, and demonstrated sexual motivation and a pursuit of sexual gratification.

115. In her GMC witness statement, Dr B stated that:

*“What I think he meant by that was that I usually wear casual, loose-fitting clothing, or I’m usually in scrubs. For the party I wore tight jeans and a tight shirt and a belt.”*

116. It was clear from Dr Prachalias’ comment that he was referring to Dr B’s appearance and the clear inference was that he liked her appearance, was obtaining pleasure or satisfaction from it, and would like to see her dressed like that, in tight fitting clothing, more often.

117. Accordingly, the Tribunal found this paragraph of the Allegation proved.

6(c)

118. The Tribunal considered that Dr Prachalias was demonstrably senior to Dr B by nature of their respective roles.

119. In Dr B's evidence she described how she was shocked and did not know how to react, given that Dr Prachalias was a more senior colleague whom she respected. When Mr Morris asked her why she did not push Dr Prachalias away, shout out or say anything to anyone at the time, Dr B replied that in addition to not expecting this, she was raised to respect people that are 'above her' and that if this had happened to her in another situation and he was not her consultant she probably would have responded in a different fashion.

120. The Tribunal was of the opinion that there was evidence that Dr Prachalias would treat colleagues differently depending on their role, seniority and experience. During her Trust investigation meeting, Dr A stated, in respect of paragraph 5 of the Allegation:

*"My role was in supporting [Dr C] as a new colleague. Would he have done that to me? Probably not. Andreas would do it to people who would not call him out."*

121. In light of the power differential between Dr Prachalias and Dr B and the evidence it had heard, including how his behaviour changed once he was appointed Clinical Director, the Tribunal found this paragraph of the Allegation proved.

### The Tribunal's Overall Determination on the Facts

122. The Tribunal has determined the facts as follows:

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

1. In or around late 2020 or early 2021, you attended a work meeting about a bed crisis after which you:
  - a. pushed open the door to Dr A's office so hard that the door hit the wall; **Determined and found proved**

- b. said to Dr A ‘Dr A get the fuckers out’, or words to that effect to which you were referring to patients and then walked out. **Determined and found proved**
2. On 1 January 2021, Dr A was explaining to you why the junior doctors were not in, and you said “Get the fuckers in” or words to that effect and then stormed off. **Determined and found proved**
3. Your conduct at paragraphs 1-2 was intimidating. **Determined and found proved**
4. On 10 December 2021, at a work Christmas party:
  - a. Dr B went to the bar to order a drink when you:
    - i. looked at Dr B up and down; **Determined and found proved**
    - ii. grabbed Dr B’s belt and pulled her towards you; **Determined and found proved**
    - iii. whispered to Dr B in her ear “why don’t you dress like that more often”, or words to that effect; **Determined and found proved**
  - b. you came up behind and leant into Dr B whilst she was dancing and said “more, more”, or words to that effect. **Not proved**
5. On 14 June 2022, Dr C attended your office for a meeting, and you said to her “Can you just go off and wait in the other room while I tell these two [Dr D and Dr E] a dirty man joke” or words to that effect. **Admitted and found proved**
6. Your actions as set out at paragraph 4:
  - a. constituted sexual harassment as defined in Section 26(2) of the Equality Act 2010, in that you engaged in unwanted conduct of a sexual nature which had the purpose or effect of violating the dignity of Dr B, or creating an intimidating, hostile, degrading, humiliating or

- offensive environment for Dr B; **Determined and found proved in respect of paragraph 4(a)**
- b. were sexually motivated; **Determined and found proved in respect of paragraph 4(a)**
  - c. were an abuse of your more senior position. **Determined and found proved in respect of paragraph 4(a)**
7. Your conduct at paragraph 5 amounted to direct discrimination in that because of Dr C's protected characteristic namely sex, you treated Dr C less favourably than you treated or would have treated others as defined in Section 13 of the Equality Act 2010. **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**

#### **Determination on Impairment - 27/03/2026**

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

#### **The evidence**

2. The Tribunal has reviewed its findings of fact and in addition, the Tribunal received further evidence as follows.

3. Dr Prachalias provided written reflections, undated, and also gave oral evidence at this stage of the hearing. Dr Prachalias gave evidence and answered questions in relation to his understanding of, and reflections on, the findings against him, and the steps he had taken to remediate and develop insight. Dr Prachalias explained that he understood the seriousness of all the findings against him, although maintained his denial in respect of Dr A and Dr B.

4. The Tribunal also received in support of Dr Prachalias a large number of testimonials from colleagues, all of which it has read.

5. The Tribunal also received additional documentary evidence from Dr Prachalias which included: Details of one-to-one Medical Ethics training *Sexual misconduct and maintaining appropriate boundaries* dated 25 November 2022; Professional Boundaries Company course materials, and; *Sexual Harassment Training for Employees* completion certificates dated 12 December 2022 and 26 February 2026.

## Submissions

### Submissions on behalf of the GMC

6. Ms Fordham, Counsel, submitted that each of the allegations admitted or found proved amount to serious misconduct and form the basis for a finding of impairment, but that given that each of the allegations involved the disrespecting of a female colleague, that common factor makes each of them more serious than if they had been isolated incidents.

7. Ms Fordham submitted that Dr Prachalias' behaviour was a serious departure from professional standards set out in *Good Medical Practice (2013)* ('GMP') and breached multiple paragraphs, specifically those in relation to respecting and valuing each person's skills and contributions, not discriminating, and treating colleagues fairly. She submitted that because of Dr Prachalias' role as Clinical Director he would have also been bound by the additional GMC guidance *Leadership and management. (2012)*, which sets out that "you must actively advance equality and diversity by creating or maintaining a positive working environment free from discrimination, bullying and harassment." She submitted that the fact that Dr Prachalias was in such a position makes his departure from the guidelines and expected standards all the more serious. She submitted that she was not seeking to make a further allegation that he failed to maintain such an environment, but that because he is held to that high standard owing to his leadership role, his personal failings were a more egregious departure from GMP.

8. Ms Fordham submitted that Dr Prachalias' behaviour towards Dr B was an even more serious a departure because it involved conduct of a sexual nature and because he abused his senior position in respect of Dr B.

9. Ms Fordham submitted that the *Guidance for MPTS Tribunals* ('the Guidance') sets out features of the allegation that may increase seriousness and that the following were applicable in this case: the behaviour being persistent or repeated; predatory behaviour; abuse of professional position, and; undermining collaborative working.

10. Ms Fordham submitted that Dr Prachalias' behaviour in respect to the allegations involving Dr B and Dr C unavoidably fall at the higher end of the spectrum of seriousness by virtue of the fact that they amount to an abuse of Dr B's dignity and discrimination in relation to Dr C's sex and that, as set out above, there are additional factors aggravating their seriousness.

11. Ms Fordham submitted that, taken alone, the allegations concerning Dr A may fall into the mid-range of the spectrum of seriousness but the fact that Dr Prachalias and Dr A were not equal makes it more serious, as does the fact that it was part of the pattern of behaviour. She submitted that the starting point for assessing the ongoing risk to public protection should therefore be considered to be high, and that on that basis, the evidence of relevant context is likely to have less impact and carry less weight.

12. Ms Fordham submitted that the Tribunal should take into account the fact that Dr Prachalias' misconduct in respect of Dr A took place against the backdrop of the COVID-19 pandemic in a work environment which was intolerably stressful for medical professionals, but the Tribunal can also take into account that that context is not ongoing, which may reduce the risk of future repetition. Ms Fordham submitted that despite this context, Dr Prachalias was in a leadership role, and it was incumbent upon him to act as a role model and not to increase the stress that others were feeling as he did in respect of Dr A. She submitted that there was a very real prospect of future events, whether that be pandemics, staff shortages or energy shortages, which might cause pressure on medical services and that there therefore remained a real risk of repetition.

13. Ms Fordham submitted that in respect of Dr B, although this did not take place within the workplace it was a work party and Dr Prachalias and Dr B did have an ongoing work relationship. Therefore, it certainly was capable of causing harm to Dr B's ability to work. She also submitted that the context of Covid was not a factor that was immediately operating upon Dr Prachalias at the time of his behaviour towards Dr B, and that in any event, sexual misconduct is one of those types of misconduct which is of a nature that is far less likely to be mitigated by factors relating to the work environment.

14. Ms Fordham submitted that Dr Prachalias' actions towards Dr C, although at work, did not appear to be the result of work-related pressures.

15. Ms Fordham submitted that a consideration of the allegations in light of Dr Prachalias' role and experience, taken on balance and in light of the applicable paragraphs within the Guidance, in fact, increase the level of current and ongoing risk to public protection.

16. Ms Fordham submitted that there had so far been no good evidence of genuine insight or of any remediation in respect of the way Dr Prachalias behaved towards Dr A and that the Tribunal identified a number of occasions and examples where witnesses other than Dr A referred to his abrasive or combative style in dealings with colleagues. She submitted that Dr Prachalias had tried to describe the matters as the perception of others rather than his own problem and that whilst he may be more careful now, he still does not accept that he was somebody who would have behaved in that way in the first place.

17. Ms Fordham submitted that despite the CPD (Continuous Professional Development) undertaken, Dr Prachalias has still not been able to accept his actions in respect of Dr B and that despite the fact that he has sought to educate himself in regard to such behaviour, he does not recognise that he conducted himself inappropriately in respect of Dr B. She submitted that any insight in respect of that is expressed in hypothetical terms only and that the allegations relating to Dr B are arguably the most serious and most difficult to remediate and also those to which Dr Prachalias has the least insight into.

18. Ms Fordham submitted that in respect of Dr C, although he has apologised to Dr C, and he did so in a timely way, there has been no real explicit recognition by him of the impact that his discrimination against Dr C had on her ability to carry out her job effectively, and no evidence of steps he has undertaken such as taking further training on leadership and team working specifically to address how he treats colleagues in the workplace.

19. Ms Fordham submitted that the seriousness of the allegations found proved, taken individually in respect of those involving Dr B and Dr C, and together involving all of the allegations, fall at the higher end of the spectrum of seriousness and that all three limbs of the definition of public protection are engaged as a result of the misconduct. She submitted that if the Tribunal find that there is a risk of repetition, then the safety and wellbeing of the public is at risk as discrimination against and intimidation of and harassing behaviour towards colleagues will mean that they are not able to work to their full potential.

20. Ms Fordham submitted that there is a risk to public confidence in the profession as a result of findings that a senior doctor spoke about patients and colleagues as "*fuckers*", has conducted himself in a sexually motivated way towards a junior colleague and has excluded a

woman from a meeting room to tell an anecdote. She submitted that, in particular, the dismissive attitude towards patients and the mistreatment of Dr B would be a concern to many members of the public.

21. Ms Fordham submitted that, perhaps most importantly, a finding that Dr Prachalias' fitness practise is impaired is necessary in order to promote and maintain proper professional standards and conduct for members of the profession.

#### Submissions on behalf of Dr Prachalias

22. Mr Morris, Counsel, submitted that it was not disputed that those matters found proved in respect of Dr A, Dr B and Dr C amount to misconduct and that in each of those cases, the behaviour fell seriously short so as to amount to misconduct.

23. Mr Morris submitted that in respect of Dr A, there is no current or ongoing risk to public protection and consequently no finding of current impairment is required. He submitted that no physical force was directed at Dr A, but it is conceded that Dr Prachalias' outbursts did amount to emotional abuse by intimidation. Mr Morris submitted that in respect of the bed crisis meeting, Dr A accepted that she did not feel threatened and that she did not find the bad language intimidating, but stated that it was the manner of his entrance and speech that was intimidating, saying during her oral evidence *'It was quite intense, almost a little bit frightening – it takes you by surprise'*.

24. Mr Morris submitted that these were two episodes of very short duration, with each only lasting a matter of seconds, and that beyond being a bit frightened in her office and shocked and tearful in the corridor, Dr A suffered no significant psychological harm. He submitted that these incidents occurred during the depth of the Covid pandemic and that New Year's Day 2021 was one of the Trust's worst days where everyone was stressed and under pressure, perhaps none more so than Dr Prachalias as the Clinical Director. He submitted that Dr A recognised this and that his outburst in her office followed a bed crisis meeting where she observed that someone had probably said the same thing to him as he said to her.

25. Mr Morris submitted that while these two incidents had the capacity to undermine collaborative working (one of the features which may increase seriousness in the Guidance) Dr A did not assert that her ability to work collaboratively with him had been reduced. He

submitted that in these circumstances this behaviour can properly be assessed to fall into the mid-range of the spectrum.

26. Mr Morris submitted that the Covid pandemic had a major impact and placed unprecedented pressures on Dr Prachalias and that these factors were present and all were outside Dr Prachalias' control. He submitted that pressures of such severity are unlikely to be repeated and that in these circumstances the likelihood of repetition is reduced and consequently the level of current and ongoing risk to public protection is decreased.

27. Mr Morris submitted that Dr Prachalias has demonstrated remediation and insight into the findings in relation to Dr A and recognised that despite unimaginable levels of stress that *'physical or verbal outbursts due to stress or frustration even in the circumstances described above are inexcusable and do not belong in a hospital environment, especially when they are perceived to target a colleague'*. He submitted that there has been no repetition since the incident.

28. Mr Morris submitted that there is therefore no ongoing risk to public protection in relation to Dr A and that a finding of impairment is therefore not required in relation to any of the three limbs of public protection.

29. In respect of Dr Prachalias' actions towards Dr B, Mr Morris submitted that Dr Prachalias accepts that a finding of current impairment in the wider public interest (maintaining public confidence and upholding professional standards) is justified. He accepted that the findings amount to opportunistic predatory behaviour and were an abuse of professional position.

30. Mr Morris submitted that the particular circumstances which mitigate the seriousness are that there was no intimate touching, that Dr Prachalias pulled Dr B close but they remained at a normal speaking distance, that the words spoken were not explicitly sexual and that the episode could only have lasted seconds. Further, this was an isolated incident and apart from the immediate shock Dr B suffered no distress or psychological harm and there was no *"significant harmful impact"*.

31. Mr Morris submitted that not all sexual misconduct falls at the higher end of the spectrum of seriousness and that this incident was towards the lower end of range of sexual misconduct and can therefore properly be characterised as falling in the mid-range of the spectrum of seriousness.

32. Mr Morris submitted that notwithstanding his denial, Dr Prachalias recognised the seriousness of the allegations from the outset and the need to address these concerns by reflection based on a number of relevant courses, which were undertaken before the Trust Investigation had been completed. He submitted that this remedial process has continued with refresher Sexual Harassment Training in February this year and that the extent of that reflection and insight is demonstrated in Dr Prachalias' written reflections and oral evidence.

33. Mr Morris submitted that the insight and remediation reduce the current and ongoing risk to public protection although Dr Prachalias accepts that it does not eliminate it in as much as the need for ensuring public confidence and maintaining standards requires a finding of impairment. He submitted that the level of risk in relation to these two parts of public protection is low and that the third part of public protection (maintaining patient safety) is not engaged as there was no lasting impact on Dr B and no suggestion of any breakdown of clinical communication or collaborative working.

34. Mr Morris submitted that in relation to Dr C, the circumstances of this misconduct do not establish that there is current and ongoing risk to public protection requiring a finding of impairment

35. Mr Morris submitted that unlawful discrimination is a serious departure from professional standards and would usually fall at the higher end of spectrum of seriousness and that Dr Prachalias' behaviour undermined collaborative working as Dr C was unable to engage effectively in the subsequent meeting and that Dr A counselled and supported her for some weeks afterwards as Dr C continued to be distressed.

36. Mr Morris submitted that this was an isolated incident with no premeditation and was unintentional. He submitted that therefore, as it was one incident devoid of any malicious or unkind intent it can properly sit in the mid-range of seriousness.

37. Mr Morris submitted that whilst Dr Prachalias was in a leadership position this was an isolated incident of discrimination and that there is only one other incident of inappropriate behaviour within the workplace, namely the intimidation of Dr A. He submitted that these two dissimilar incidents do not establish that Dr Prachalias was *'frequently demonstrating inappropriate behaviour'*, the threshold set out in the Guidance for having an additional impact on workplace culture and that the facts of the case as outlined above do not warrant finding an increase in the level of current and ongoing risk to public protection.

38. Mr Morris submitted that Dr Prachalias accepted that he had behaved inappropriately towards Dr C and was apologetic and promptly apologised to her when it was raised with him. He submitted that this immediate insight continued and is set out in his written reflections, that there has been no repetition in the two and a half years since Dr Prachalias returned to work in September 2023, demonstrating his effective remediation.

39. Mr Morris submitted that while the Guidance Introduction says that it will be unusual for unlawful discrimination not to undermine public confidence in profession, in the particular circumstances of this case there is now no current and ongoing risk to public protection in any of its three parts and consequently no need to make a finding of impairment.

### **The relevant legal principles**

40. There is no burden or standard of proof at this stage of the proceedings and the decision of impairment is a matter for the Tribunal's judgment alone. The Tribunal will only make a finding of impairment where there is a legal basis for doing so and where a decision is reached that the doctor poses a current and ongoing risk to one or more of the three parts of public protection which is likely to require restrictive action in response. The three parts of public protection are to protect, promote and maintain the health, safety and well-being of the public; to promote and maintain public confidence in the profession; and to promote and maintain proper professional standards and conduct for members of the profession.

41. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct, and that the misconduct was serious, and then whether the finding of serious misconduct poses a current and ongoing risk to public protection requiring restrictive action in response and therefore could lead to a finding of impairment.

42. To assess whether Dr Prachalias poses any current and ongoing risk to public protection which may require restrictive action in response, the Tribunal will consider:

- where on the spectrum of seriousness the allegation lies, based on the facts found proved;
- the impact of any relevant context known about Dr Prachalias and/or their working environment, and;

- how Dr Prachalias has responded to the allegations.

### The Tribunal's determination on impairment

#### Is there a legal basis for considering impairment?

43. The Tribunal first considered whether the facts admitted and found proved amounted to misconduct. In doing so it noted the submission made on behalf of Dr Prachalias that he accepted that on the matters found proved in relation to Dr A, Dr B and Dr C, in each of those cases, the behaviour fell seriously short so as to amount to misconduct.

44. The Tribunal considered that Dr Prachalias' intimidating behaviour towards Dr A, his sexually motivated misconduct towards Dr B and his discriminatory behaviour towards Dr C were all serious departures from GMP. It concluded that in all three cases, Dr Prachalias' actions breached paragraphs 1, 35, 36 and 37, as set out below:

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

*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.*

45. The Tribunal also considered that Dr Prachalias' action towards Dr C breached paragraph 59, which states:

*59 You must not unfairly discriminate against patients or colleagues by allowing your personal views to affect your professional relationships or the treatment you provide or arrange...*

46. The Tribunal considered that Dr Prachalias' conduct, directed towards three female colleagues, fell seriously below the standards expected and that his actions towards Dr A, Dr B and Dr C amounted to misconduct, both individually and cumulatively.

47. The Tribunal was satisfied, having found Dr Prachalias' actions towards Dr A, Dr B and Dr C individually amounted to misconduct, that there was a legal basis for a finding of impairment.

48. The Tribunal therefore went on to consider whether, as a result of that misconduct, Dr Prachalias' fitness to practice is currently impaired.

Where on the spectrum of seriousness does the allegation lie?

49. The Tribunal considered that the additional GMC guidance *Leadership and management. (2012)* was applicable to Dr Prachalias, who was the most senior person at the Unit at the time. It accepted that there was no specific allegation that Dr Prachalias had breached this additional guidance. However, by virtue of his position, the Tribunal considered it alongside the Guidance, in respect of each individual allegation.

50. The Tribunal received a large number of testimonials from colleagues of Dr Prachalias, which attested to his competency as a practitioner and did not reflect any of the concerns with his interactions with colleagues as found at the facts stage. However, the Tribunal attributed these little weight at this stage of proceedings (the Guidance indicates that testimonials are more appropriately considered at the sanction stage) and in light of the seriousness of its findings.

Dr A

51. The Tribunal initially considered that the Guidance indicated that as a starting point Dr Prachalias' behaviour towards Dr A fell at the lower end of the spectrum of seriousness. It had particular regard to the following factor set out in the Guidance:

*an incident of violent or abusive behaviour which is limited in nature and had limited impact, such as where it occurred outside of the doctor's professional role and did not cause any significant physical injuries or any significant physical, emotional or psychological harm.*

52. The Tribunal considered that Dr Prachalias' language and behaviour was not directed at Dr A or targeted at any specific individuals, but at the difficult circumstances in relation to a bed crisis and junior doctors' absence during the height of the Covid pandemic. Dr A found Dr Prachalias' behaviour and words intimidating but it did not appear that he was intending to intimidate her.

53. However, Dr Prachalias' behaviour towards Dr A was repeated, occurring on two occasions, and the Guidance indicates that repeated or persistent behaviour is a feature which may increase the seriousness of the allegation.

54. In respect of undermining collaborative working, which is also a feature that may increase seriousness, the Tribunal accepted the submission made on behalf of Dr Prachalias that while these two incidents had the potential to undermine collaborative working, Dr A did not assert that her ability to work collaboratively with him had been reduced as a result.

55. The Tribunal concluded that the repeated nature of Dr Prachalias' behaviour, which occurred in his professional role was an abuse of his professional position by virtue of his seniority and role, was an aggravating factor which increased the seriousness to the mid-range of the spectrum of seriousness. As such, the starting point for assessing the risk to public protection was medium.

#### Dr B

56. In considering the seriousness of Dr Prachalias' behaviour towards Dr B, namely the unwanted touching and comments which constituted sexual harassment and were sexually motivated, the Tribunal had regard to the introductory section of the Guidance. This sets out the following in relation to sexual misconduct:

*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.*

57. The Tribunal considered that Dr Prachalias' behaviour, whereby he looked her up and down, pulled her near to him by her belt and said "why don't you dress like that more often" fell towards the lower end of the spectrum of sexual misconduct. The Tribunal acknowledged the submissions made on behalf of Dr Prachalias that there was no intimate

touching, they remained at a normal speaking distance, that the words spoken were not explicitly sexual and that the episode could only have lasted seconds.

58. However, the Tribunal determined that due to its nature, this behaviour still fell at the higher end of the spectrum of seriousness.

59. In terms of factors which may increase the seriousness of the allegation, the Tribunal concluded that Dr Prachalias' behaviour was of an opportunistically predatory nature and was an abuse of his professional position.

60. The Tribunal noted that an abuse of professional position can occur both inside and outside a doctor's working life and noted that whilst this did not occur at work, it was a work event. The Tribunal's view is that Dr Prachalias' behaviour was influenced by his seniority to Dr B which contributed to him feeling that he could behave in the way that he did.

61. In respect of undermining collaborative working, which is also a feature that may increase seriousness, the Tribunal accepted the submission made on behalf of Dr Prachalias that apart from the immediate shock to Dr B, she suffered no distress or psychological harm and there was therefore no "*significant harmful impact*". The Tribunal also bore in mind that XXX.

62. The Tribunal concluded that the allegation fell at the higher end of the spectrum of seriousness which was increased by the factors set out above. Accordingly, the starting point for assessing the risk to public protection was high.

#### Dr C

63. In considering the seriousness of Dr Prachalias' actions towards Dr C, the guidance indicates that "*unlawfully discriminating in relation to characteristics protected by law*" would usually fall at the higher end of the spectrum of seriousness.

64. The Tribunal also considered that the following features increased the seriousness of the allegation: Dr Prachalias' behaviour was an abuse of his professional position and undermined collaborative working. The Tribunal was of the opinion that Dr Prachalias' seniority over Dr C contributed to him feeling able to exclude her from a discussion on the basis of her sex and it received evidence demonstrating that this had affected Dr C and contributed to a dysfunctional meeting as a result.

65. The Tribunal therefore concluded that the allegation fell at the higher end of the spectrum of seriousness and was increased by the factors set out above. Accordingly, the starting point for assessing the risk to public protection was high.

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

66. In terms of personal context, there were no applicable features which the Tribunal could identify in relation to Dr A, Dr B or Dr C, and Mr Morris made no positive submissions in this respect on Dr Prachalias' behalf.

67. Accordingly, the Tribunal went on to consider whether there were any features of Dr Prachalias' working life it should take into account.

Dr A

68. In terms of Dr Prachalias' working environment, the Tribunal accepted that the Covid pandemic had led to unprecedented pressures and that as the Clinical Director, this would have put extraordinary stress upon Dr Prachalias' at the time. The Tribunal was mindful of the Guidance, which indicates that contextual factors which can directly or indirectly affect a doctor's behaviour are "workload issues, such as unmitigated gaps in resources, a crisis or unexpected surge in demand".

69. Dr A herself acknowledged this context, stating in her GMC witness statement that:

*"When Covid hit, that was a huge stressor. As Clinical Director, Andreas was attending Trust Silver and Gold Command meetings. I could see there was a lot of pressure on him to enact certain things. One of the huge stressors was around staffing during the pandemic – cases were piling up; people were working round the clock and staff were 'dropping like flies' as they were infected with covid.*

...

*I understand he was stressed, and he'd probably just had someone shout at him, but it's very difficult to work in an environment when people are acting like that."*

70. The Tribunal acknowledged that there were acute bed shortages and staffing issues at the Unit which may have affected Dr Prachalias' behaviour at the time. The Tribunal considered that this did somewhat decrease where the allegation fell on the spectrum of seriousness and the corresponding risk to public protection.

Dr B

71. There were no applicable features which the Tribunal could identify in relation to Dr B and no positive submissions made on Dr Prachalias' behalf.

Dr C

72. The Tribunal considered that whilst the incident with Dr C did occur at the workplace and within the broader context of the Covid pandemic, this was a usual business meeting and that the aforementioned context did not affect his behaviour. Dr Prachalias' decision to tell an anecdote to two male colleagues and exclude Dr C was not a result of work-related pressures. It was a calm decision made by him.

73. In respect of Dr C, the Tribunal considered that Dr Prachalias' role and experience was relevant. It had found that Dr C was negatively affected by Dr Prachalias' behaviour, which undermined collaborative working. Accordingly it considered the following paragraphs of the Guidance:

*63. Doctors in leadership positions have specific standards set out in Good medical practice and other detailed professional guidance that they're expected to practice in line with. Where a doctor is in a senior or leading role, the additional impact their poor behaviour or performance has had, or could have had, can be considered.*

*66. Where the doctor was in a leadership position at the time the circumstances giving rise to the allegation arose and the behaviour or poor performance had, or could reasonably have had, a negative impact on others in the working environment, this may, depending on the facts of the case, increase the level of current and ongoing risk the doctor poses to public protection. The doctor no longer being in that role will not usually have the effect of reducing the level of current and ongoing risk posed to public protection because it is possible they will return to that, or a similar, position in the future.*

74. The Tribunal considered that Dr Prachalias' seniority and the impact on Dr C therefore increased the risk to public protection.

How has Dr Prachalias responded to the allegations?

75. The Tribunal noted that there was no suggestion that Dr Prachalias had not kept his skills and knowledge up to date; he had returned to practice shortly after the incidents the Tribunal is concerned with. The Tribunal also received a large number of testimonials clearly demonstrating his clinical excellence.

76. The Tribunal therefore went on to consider insight and remediation in respect of the individual allegations.

77. In considering insight, the Tribunal had particular regard to the following paragraph of the Guidance:

*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*
- *sought appropriate support for a health condition and are seeking and/or following treatment and advice and/or are engaging with local support and any steps put in place to manage any risks to patients*
- *complied with the professional duty of candour*
- *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 GMC.*

Insight & Remediation

78. In relation to all three complainants/incidents, the Tribunal reminded itself of the approach to be taken when assessing the insight of a doctor who has denied the allegation as set out in *Sawati v GMC [2022] EWHC 283*. A doctor is entitled to a robust defence against an allegation and a denial should not be held against them. However, a Tribunal is entitled to look at how a doctor approaches findings against them and their response.

79. In this regard, the Tribunal was mindful of the following paragraphs of the Guidance:

*89. A doctor has the right to advance a robust defence to an allegation. This includes requiring the GMC to prove their case and bring witnesses to hearings. As a result, an apology may not be forthcoming until after a witness has engaged in the hearing. In other cases, if the defence put forward by the doctor is not successful, it may be unrealistic to expect them to immediately accept every finding, in a fully sincere manner, or apologise.*

*90. However, in these circumstances it may still be possible for the doctor to provide some evidence of insight without them having fully admitted the circumstances of the allegation. Where a doctor gives evidence at a hearing, the MPT will be able to test evidence of insight through oral testimony to assess whether it is genuine.*

#### Dr A

80. Dr Prachalias sought to persuade the Tribunal that he had undertaken a number of relevant courses and recognised the impact of his behaviour. However, given his evidence and answers to questions put to him, the Tribunal found his insight to be theoretical in approach and therefore superficial. It was not rooted in his actual actions and his acknowledgment of those actions. It was not reflective of the wider body of evidence as to how he behaved in his role.

81. In his oral evidence at the facts stage Dr Prachalias insisted that he maintained “*measured and calm behaviour in addressing people and issues in meetings*”.

82. In his written reflections provided to the Tribunal at this stage of proceedings, Dr Prachalias stated that:

*“Consequently, though in times of high stress I may raise my voice in exceptional circumstances, I consciously choose to remain collected and reserved, so that I never*

*have such egregious lapses in my composure. I now better understand that impact is more important than intention. Even if my purpose in any interaction was to expedite patient care, that does not mitigate the effect on a colleague who may have felt undermined, belittled or distressed. I deeply regret any such impact.”*

83. In his oral evidence at this stage of proceedings, Dr Prachalias stated that *“I do offer my opinions in a stern way, but I wouldn't describe or I didn't have a recollection of myself being combative”*. The most he conceded was that the perceptions of what he says or the way he says it could cause people to be upset or threatened or intimidated.

84. When asked by Ms Fordham during cross-examination whether he believed that the accounts of various other doctors regarding his behaviour and tone were a problem of perception rather than a problem of how he behaved, Dr Prachalias responded that he understood how people could adversely perceive what he said and that he believed that this had to do with the position that he was holding at that time.

85. The Tribunal had some concerns that Dr Prachalias' position and understanding of his own behaviour did not appear to have sufficiently progressed. From the outset, he stated that he took a calm and measured approach and following the Tribunal's findings at the facts stage suggested that he would maintain a calm and measured approach. The only concessions he appeared to make were that he would sometimes raise his voice and that he now understood that people might *“perceive”* his actions to be angry, aggressive or intimidating, although he denied that he was *“combative”*, however this was *“more impact than intention”*.

86. During his oral evidence and in response to Tribunal questions, Dr Prachalias was unable to demonstrate fuller insight, how his behaviour had changed or apply this to himself and his practice specifically. The examples he gave were that he recalled that at MDT (Multi-Disciplinary Team) meetings he would discuss differing opinions to his and suggest his own recommendations, and that on ward rounds he would try to understand why things that should be available such as blood results were not, such as issues involving lapses of concentration, and give a very polite explanation to colleagues as to the importance of doing their job in the proper time. The Tribunal considered that these were examples of normal, expected interactions and did not represent development of meaningful insight.

87. The Tribunal considered that Dr Prachalias had failed to recognise the extent or impact of his behaviour and his approach to colleagues, including Dr A and had not

acknowledged concerns raised by a number of colleagues about his approach, demeanour and style of communication.

88. The Tribunal heard undisputed evidence as to the difficult, toxic and male-orientated culture within the Unit, as described in its facts determination. Dr Prachalias' evidence was that he was appointed as Clinical Director and was given a mandate by the Trust to improve the situation. The Tribunal considered that on the basis of its findings, Dr Prachalias had in some instances contributed to this toxic culture. Dr A, Dr B and Dr C were all female colleagues and although the Tribunal heard how he had increased the number of female colleagues and introduced single sex changing rooms, it heard little evidence from him as to steps he had taken to address the culture more broadly, a culture he himself acknowledged existed. There was little meaningful evidence of reflection or remediation in relation to his teamwork and leadership.

89. The Tribunal determined that Dr Prachalias' insight was developing but limited and that his remediation was incomplete. He appeared to minimise his actions and behaviour, which he did not accept, and framed the issues in terms of perception. The Tribunal was concerned that given his role and remit, he did not appear to grasp the impact of his behaviour either to the individuals involved or the wider culture.

90. In relation to the risk of repetition, the Tribunal accepted that the acutely pressured and stressful circumstances of the Covid pandemic were no longer present, potentially reducing the risk of repetition, and that there had been no repeat of such behaviour since.

91. The Tribunal was of the opinion that these proceedings and the finding of misconduct will have had a salutary effect on Dr Prachalias and reduced the risk of repetition of this specific behaviour, namely him swearing to colleagues.

92. However, the Tribunal considered that similarly stressful or pressured circumstances arising in future could not be ruled out and that until Dr Prachalias demonstrated meaningful insight into how he reacted to such situations and the way he treated colleagues, a risk of repetition of similar behaviour remained.

#### Dr B

93. The Tribunal considered that Dr Prachalias had not had much time to consider the findings of the Tribunal and demonstrate full insight.

94. However, Dr Prachalias has consistently accepted that such behaviour falls seriously below the standards expected and would require a finding of impairment to uphold public confidence and to maintain standards in the medical profession. He has also engaged in some relevant CPD and made attempts to remediate and demonstrate insight. Further, there has been no repetition of any similar behaviour since the events.

95. The Tribunal however considered Dr Prachalias' insight and reflections into this matter remains limited. He continues to assert that he has no recollection of the incident and would not have acted in the manner alleged. When questioned during his oral evidence, Dr Prachalias' reflections and insight appeared to be a hypothetical and intellectual exercise where he was able to recognise the seriousness of the behaviour and the impact to public protection as a concept. He was however unable to relate that to himself and his actions due to his denial. As such he was unable to demonstrate meaningful insight beyond the conceptual.

96. The Tribunal considered that Dr Prachalias' response did not sufficiently examine his own behaviour and the impact on Dr B, and that his insight was not sufficiently developed. The Tribunal considered that as Dr Prachalias has not fully accepted the findings against him or demonstrated full insight, he has not yet sufficiently remediated the behaviour and needs to reflect further on his own conduct and its impact.

97. In relation to repetition, the Tribunal reminded itself of the Guidance that misconduct of a sexual nature is generally difficult to remediate. However it noted that whilst inherently serious, the circumstances in this case fell towards the lower end of the spectrum of sexual misconduct.

98. The Tribunal considered that there was a low risk of repetition of such behaviour, but in the absence of developed, meaningful insight into his conduct, some risk of repetition remained.

#### Dr C

99. The Tribunal noted that in respect of Dr C, Dr Prachalias admitted his wrongdoing and apologised immediately once it was brought to his attention. He subsequently attended courses on professional boundaries and ethics.

100. In his witness statement, oral evidence and written reflections, Dr Prachalias described how and why he acted in the manner that he did and accepted that this fell short of the standards accepted. He had acted as he did in a warped sense of “*consideration*” and in Dr C's best interest, as the anecdote was “*perhaps in poor taste*”. He accepts that he exercised poor judgement and failed to uphold the standards of equality and professionalism expected of him, and that in excluding Dr C he was discriminating against her.

101. The Tribunal considered that he had demonstrated timely insight into the matter, reflected on the issue and modified his own behaviour and practice. The Tribunal noted this was in contrast to the other areas of misconduct.

102. The Tribunal considered that in light of his insight and remediation, Dr Prachalias was unlikely to repeat such behaviour and that the risk of repetition was therefore low.

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

103. The Tribunal next had to consider, overall, whether Dr Prachalias poses any current and ongoing risk to public protection which may require restrictive action on his registration, and its decision on impairment.

104. In respect of Dr Prachalias’ behaviour towards Dr A, taking into account the features set out above, the Tribunal determined that the starting point for assessing the risk to public protection was medium when considered in isolation. However, Dr Prachalias’ actions appeared to be part of a broader issue regarding his approach to, and communication with, colleagues and the Tribunal was concerned that he still lacked meaningful insight into this.

105. In respect of Dr B, the Tribunal considered that the risk to public protection was necessarily high owing to the nature of the allegation and the relevant factors increasing where this fell on the spectrum of seriousness.

106. In respect of Dr C, the Tribunal considered that although Dr Prachalias did have good insight, the context and nature of the allegation meant that the risk to public protection was also high.

107. Overall the Tribunal assessed the risk to public protection as high. Dr Prachalias’ conduct occurred over a period of time in different settings and was linked to his senior

position. This behaviour occurred within a culture described as “toxic” where Dr Prachalias was in the senior, leadership role. The behaviour was directed towards three female colleagues.

108. In relation to patient safety, the Tribunal determined that Dr Prachalias’ conduct had not placed patients or members of the public at any significant risk of harm. Whilst it accepted that Dr Prachalias actions in respect of Dr C had undermined collaborative working, which could potentially put patients at risk, it had received no evidence of any harm resulting from this. Accordingly, it determined that a finding of impairment was not necessary in order to uphold the first limb of public protection, namely to protect, promote and maintain the health, safety and well-being of the public.

109. In relation to public confidence, the Tribunal determined that a fully informed member of the public would be seriously concerned by Dr Prachalias’ conduct, in particular his sexually motivated conduct towards Dr B and the abuse of his professional position. Accordingly, it determined that a finding of impairment was necessary in order to uphold the second limb of public protection, namely to promote and maintain public confidence in the medical profession

110. In relation to professional standards, the Tribunal determined that a finding of impairment was necessary to uphold the fundamental standards of the profession. This was particularly the case owing to Dr Prachalias’ seniority and the higher standards he was expected to adhere to in these circumstances.

111. Accordingly, the Tribunal determined that a finding of impairment was necessary in order to uphold the second and third limbs of public protection.

112. The Tribunal has therefore determined that Dr Prachalias’ fitness to practise is impaired by reason of his misconduct.

#### **Determination on Sanction - 21/05/2026**

#### **The Evidence**

1. 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

2. The Tribunal received further evidence on behalf of Dr Prachalias including:
  - Witness evidence from Professor O, Consultant Intensivist and Associate Medical Director at Guy’s and St Thomas’ NHS Foundation Trust, Professor of Intensive Care Medicine at King’s College London, Director of Critical Care Services for HCA UK, and Director of the Intensive Care Unit at London Bridge Hospital. Professor O gave evidence in person and also provided a testimonial witness statement dated 8 May 2026;
  - Testimonials in support of Dr Prachalias from two further colleagues;
  - Documentary evidence which included, but was not limited to:
    - Patient feedback report dated 26 July 2024;
    - Thankyou cards from patients, various dates/undated;
    - Documentation of articles published by Dr Prachalias dated February 2026 and April 2026;
    - Evidence of Consultant of the Year award presented to Dr Prachalias in 2019.

## Submissions

### On behalf of the GMC

3. On behalf of the GMC, Ms Fordham submitted that the appropriate sanction in this case was one of erasure.
4. Ms Fordham submitted that in respect of Dr A, the Tribunal found that the starting point was that the risk to public protection was medium and noted that Dr Prachalias’ actions appeared to be part of a broader issue regarding his approach to, and communication with, colleagues. She submitted that within the Guidance for MPTS Tribunals (‘the Guidance’) the sanctions banding for abusive behaviour indicates suspension for 3 to 12 months where the risk to public protection is medium.
5. Ms Fordham submitted that in respect of Dr B and Dr C, the Tribunal found the risk to public protection to be high. She submitted that the sanctions banding for sexual misconduct, where there is a higher level of risk to public protection is 12 months’ suspension to erasure and for discriminatory behaviour, where there is a higher level of risk, the banding is 9 months’ suspension to erasure.

6. Ms Fordham submitted that any additional evidence relevant to the decision on sanction should be given limited weight given that this is a case where there are multiple allegations falling at the higher end of the spectrum of seriousness. She submitted that clearly erasure would have a significant effect on Dr Prachalias and the department within which he practices, but the impact of the sanction should be given little weight given the seriousness of the findings. She submitted that the same principle applies to the relevance of references and testimonials provided on behalf of Dr Prachalias. Dr Prachalias' clinical abilities have not been called into question, nor has the Tribunal found there to be a risk to patient safety, limited significance should be given to the testimonials and references which speak to his performance as a doctor.

7. Ms Fordham submitted that there are no exceptional circumstances which exist in this case which would justify the Tribunal taking no action. The Tribunal has found the overall risk level to be high and therefore it would not be appropriate for no action to be taken.

8. Ms Fordham submitted that conditions are not an appropriate response in this case as the nature of the allegations found proved in respect of Dr B and Dr C fall at the higher end of the spectrum of seriousness, and as the Tribunal's findings in respect of Dr A were that Dr Prachalias' behaviour appeared to be, *"part of a broader issue regarding his approach to, and communication with, colleagues..."*

9. Ms Fordham submitted that Dr Prachalias' actions occurred over a period of around 18 months between the end of 2020 and June 2022 and whilst he was in a senior leadership position. Further, the Tribunal's findings in respect of the allegations concerning Dr A and Dr B (the latter arguably being the most serious of the allegations) were that Dr Prachalias had limited insight into his conduct. She submitted that these factors suggest that suspension would not be appropriate and that the attitudes which led to Dr Prachalias conducting himself in this way will not be changed over the period of a suspension. She submitted that Dr Prachalias has shown a persistent lack of insight into the seriousness of the allegations and in respect of his actions towards Dr A and Dr B

10. Ms Fordham submitted that the Tribunal has also indicated that Dr Prachalias' actions overall are suggestive of a wider problem with his ability to communicate appropriately with colleagues and to treat them with respect. She submitted that this problem appears to manifest itself particularly in his dealings with female colleagues and that shouting at, sexually harassing and excluding female colleagues are matters which, in the GMC's submission, are actions which are fundamentally incompatible with continued registration.

11. Ms Fordham submitted that, therefore, this is a case where erasure is the only appropriate response. She submitted that the Guidance states that erasure may be the only proportionate response where: *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 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.*

12. Ms Fordham submitted that the Tribunal found at the impairment stage that Dr Prachalias' actions appeared to be part of a broader issue regarding his approach to and communication with colleagues and that he still lacked meaningful insight into this issue. She submitted that the Tribunal also found that facts found proved in respect of Dr B and Dr C fell at the higher end of seriousness as they concerned sexual allegations and discrimination. Further, she submitted, in finding that the overall risk to public protection was high and considering the impact of any relevant context, the Tribunal remarked that the *“conduct occurred over a period of time in different settings and was linked to his senior position”*. It also took place, *“within a culture described as ‘toxic’ where Dr Prachalias was in the senior leadership role”* and in respect of three female colleagues. She submitted that all these factors tend to suggest that the effect of Dr Prachalias continuing to hold registration would undermine public confidence in the profession.

13. Ms Fordham submitted that the seriousness of the facts found, taken in the context within which the behaviour occurred, coupled with the limited insight demonstrated means that the risk to public protection remains high and therefore erasure is the only sanction which meets the need to promote and maintain public confidence in the profession and to uphold the fundamental standards of the profession.

14. In respect of the case law of *Giele v GMC [2005] EWHC 2143 (Admin)* provided by Mr Morris, Ms Fordham submitted that this is a 2005 case and predates the Guidance by a couple of decades. She submitted that the details of that case differ from this one and so the testimonials therefore can not quite address the findings in the same way, and that the Tribunal should consider the Guidance, which states:

*72. Whilst greater emphasis can usually be placed on testimonials that have been verified, the question of how much weight to be given to evidence provided in references*

*and testimonials is a matter for the MPT's judgment, having regard to their earlier assessment of the level of current and ongoing risk to public protection posed by the doctor. But in most cases, particularly in those where the allegation fell at the higher end of the spectrum of seriousness and the level of current and ongoing risk to public protection remained high, this type of evidence may have limited, if any, impact because the need to protect the public will outweigh any relevant evidence about the doctor's character.*

On behalf of Dr Prachalias

15. On behalf of Dr Prachalias, Mr Morris submitted that Dr Prachalias accepts that the proved facts upon which the finding of impairment has been made require a sanction of suspension in order to protect the public interest, and that conditional registration would not be appropriate in the circumstances.

16. Mr Morris submitted that the features of the intimidation of Dr A when considered in isolation set an initial assessment of the risk to public protection as medium and that the related sanction banding is suspension between 3 and 12 months. He submitted that the features of the sexual misconduct with Dr B necessarily required an assessment of risk as high and that the related sanction banding is 12 months suspension to erasure. He submitted that the context and nature of the features of the discrimination towards Dr C required an assessment of risk as high and that the related sanction banding is 9 months suspension to erasure.

17. Mr Morris submitted that the Tribunal noted that in relation to Dr A, Dr Prachalias' intimidating behaviour was not targeted at Dr A or any other individual, was not intended to intimidate and that Dr A's ability to work collaboratively was not reduced. It had found that the working environment during the pandemic decreased the seriousness, that this stress was no longer present and there had been no repetition during the subsequent 5+ years and that these proceedings and the finding of misconduct had had a salutary effect on Dr Prachalias and reduced the risk of repetition. He submitted that, nevertheless, the Tribunal found that similar stresses might recur in future and, given that Dr Prachalias' insight was limited but developing and remediation was incomplete, a risk of repetition remained.

18. Mr Morris submitted that the Tribunal noted that in relation to Dr B, Dr Prachalias' behaviour fell towards the lower end of the spectrum of sexual misconduct but its inherent nature placed it at the higher end of the spectrum of seriousness and that this was increased

by its predatory nature (which was opportunistic rather than premeditated) and its abuse of his senior professional position. He submitted that the Tribunal found that it did not undermine Dr B's ability to work collaboratively, that there had been no repetition of any similar behaviour during the subsequent 4+ years and that the risk of repetition was low. However, the Tribunal found that Dr Prachalias' insight remained limited and therefore some risk of repetition remained.

19. Mr Morris submitted that the Tribunal noted that in relation to Dr C, Dr Prachalias' unlawful intimidation of Dr C fell at the higher end of the spectrum of seriousness which was increased by his abuse of his senior professional position and the undermining of Dr C's ability to work collaboratively. He submitted that Dr Prachalias' acceptance of his misconduct was timely, that he had shown good insight and modified his behaviour, that there had been no repetition during the 4 subsequent years and that he was unlikely to repeat this behaviour and so the risk of repetition was therefore low.

20. Mr Morris submitted that when deciding what sanction was appropriate, the Tribunal should determine what is required but no more than necessary to achieve public protection, approaching the question by considering if the least restrictive action is appropriate, as set out in the Guidance. He submitted that the Tribunal has found that Dr Prachalias had not placed patients or members of the public at any significant risk of harm and that a finding of impairment was therefore not necessary for the purpose of upholding the first limb of public protection. He submitted that as such, a sanction is only needed in the wider public interest.

21. Mr Morris submitted that the Guidance sets out that *"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 unbecoming a registered doctor."* He submitted that the following factors set out within the Guidance are present in this case and establish that suspension may be proportionate: *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 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.'*

22. Mr Morris submitted that the Guidance states that erasure is used to protect the public *in the most serious cases* and sets out that:

57. 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.*

He submitted that while it is accepted that conditions are not appropriate and factor (a) is present, factors (b)-(d) are not.

23. Mr Morris submitted that the Guidance establishes sanction bandings and that when viewing the three types of misconduct overall the, bandings give rise to a provisional view that the appropriate length of suspension is 12 months. However, the Guidance identifies that there may be factors and evidence which justify a final decision departing from the length of suspension set out in the bandings. He submitted that in this context the Guidance states:

*A short suspension may be appropriate in cases where: the doctor's behaviour fell at the higher end of the spectrum of seriousness; there was evidence of relevant context and/or evidence of insight and remediation that decreased the level of current and ongoing risk to public protection such that there are no outstanding patient safety considerations; and suspension is being imposed on public confidence grounds and/or to maintain professional standards.*

and:

*When considering the impact on those affected by the decision, the interests of individual patients and members of the public may include the impact that taking a specific type of action is likely to have on the delivery of health services in a particular speciality or within a defined geographical location.*

24. Mr Morris submitted that the references and testimonials before the Tribunal disclose that Dr Prachalias is an exceptional surgeon and doctor in his field and that Dr Prachalias is of previous good character with no adverse regulatory findings. He submitted that the references and testimonials before the Tribunal disclose extensive evidence from many medical and other clinical colleagues who have not seen or heard directly or indirectly by formal or informal complaint any inappropriate conduct by Dr Prachalias and who all consider the misconduct outwith his character.

25. Mr Morris submitted that these factors justify a final decision by the Tribunal to impose a period of suspension shorter than provisionally indicated by the Guidance's sanction bandings.

26. Mr Morris submitted that the case of *Giele v GMC [2005] EWHC 2143 (Admin)* was relevant and sets out that “...the existence of a public interest in not ending the career of a competent doctor will play a part” and “So long as the public interest in retaining the services of a competent practitioner is a relevant consideration, it is inevitable that the weight to be attached to this aspect will to some extent depend on the abilities of the practitioner in question.”

27. Mr Morris submitted that these principles are reflected in the following paragraphs of the Guidance:

10. ...

*When considering the impact on those affected by the decision, the interests of individual patients and members of the public may include the impact that taking a specific type of action is likely to have on the delivery of health services in a particular speciality or within a defined geographical location. However, whilst there may be a public interest in facilitating a doctor's return to safe practice, the decision on what sanction is required needs to reflect the level of current and ongoing risk to one or more of the three parts of public protection that has been identified, and which takes into account the seriousness of the allegations, and must be consistent with the GMC and MPTS' legal role to protect the public.*

*66. The following matters are not relevant to the assessment of current and ongoing risk to public protection which will have informed the MPT's decision on impairment, but can be considered at this stage when deciding what sanction is proportionate:*

- a. evidence about the impact that taking a specific type of action may have on patients or members of the public, or the doctor themselves, and/or*
- b. references and testimonials about the doctor's character.*

28. Mr Morris submitted that the Tribunal has received testimonial evidence demonstrating that Dr Prachalias is an exceptional surgeon and doctor in his field, within a very specific area where he is among the very few surgeons in the world who perform auxiliary live donor liver transplants. He submitted that the Tribunal has also received evidence that Dr Prachalias' absence from practice has been regarded by many colleagues as depriving the profession and patients of his surgical excellence. He submitted that the Tribunal should therefore consider these factors when reaching its decision on sanction.

### The Tribunal's Determination on Sanction

29. The Tribunal was reminded that the decision as to the appropriate sanction, if any, to impose is a matter for its independent judgement. When determining whether to impose a sanction and, if so, when determining the appropriate sanction, it should have regard to the principle of proportionality and should start by considering the least restrictive option. It had regard to paragraphs 7 and 8 set out in the Guidance Introduction, which states:

*'Being proportionate*

*7. To be proportionate, a tribunal must ask themselves, in the context of the individual case and decision being made, what is required and no more than necessary to meet the GMC and MPTS' legal duty to protect the public in a timely way. To assess what is proportionate, tribunals should be clear on the options available to them.*

*8. Where appropriate, tribunals can consider the impact on those affected by the decision. This will include the interests of individual patients and members of the public, colleagues and the interests of the doctors the GMC regulates, including the individual doctor. But in all cases, the need to protect the public from any risk posed by a doctor, is more important than the interests of any individual.*

30. In making its decision on sanction, the Tribunal has reviewed its decisions on facts and impairment and has considered the level of current and ongoing risk the doctor poses to public protection. It has also considered any new evidence which may impact the level of

current and ongoing risk to public protection. It has referred to the sanctions bandings for sexual misconduct, violent or abusive behaviour and discrimination as set out in Part C of the Guidance. It has also considered the impact of any specific sanction type, where applicable, and any references or testimonials provided.

31. The Tribunal reminded itself of its finding at the impairment stage that the risk to public protection in relation to Dr A was medium, and was high in relation to Dr B and Dr C. It had determined that the second and third limbs of public protection were engaged in this case, namely to promote and maintain public confidence in the profession (public confidence), and to promote and maintain proper professional standards and conduct for members of the profession (uphold professional standards).

32. The Tribunal noted that the indicative sanctions banding set out in the Guidance indicated a period of suspension between 3 to 12 months for cases involving violent or abusive behaviour with a medium level of risk to public protection. For cases involving sexual misconduct with a higher level of risk to public protection it indicates a period of suspension for 12 months to erasure. For cases involving discrimination with a higher level of risk to public protection it indicates a period of suspension of 9 to 12 months to erasure.

33. The Tribunal went on to consider whether there were any factors which would affect its earlier assessment of the risk to public protection, particularly given the passage of time of approximately seven weeks between the impairment and sanction stages. It noted that no further issues or concerns had been brought to its attention.

34. The Tribunal also considered that Dr Prachalias had accepted the findings of the Tribunal and instructed his counsel, Mr Morris, to make the submission that a period of suspension was the lowest appropriate sanction in this case given the Tribunal's findings. The Tribunal was of the opinion that this acknowledgement of the seriousness of the findings was reflective of the further development of insight by Dr Prachalias.

35. The Tribunal concluded that there were no factors or evidence which would impact its earlier assessment of the risk to public protection and so its starting point when considering sanction remained the same.

36. The Tribunal also reminded itself that it had heard evidence in relation to the toxicity of the workplace and tensions within the Hospital at the time of events. However, there had

been no formal allegations made in this respect and the Tribunal therefore focused its determination on the specific allegations and its earlier findings in that regard.

37. Although the Guidance includes indicative sanctions bandings, as set out above, the Tribunal acknowledged that these are indicative rather than binding and any decision on sanction is one ultimately for the Tribunal. Accordingly, the Tribunal started its consideration at the lowest possible sanction.

### No action

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

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

40. In reaching this decision it also noted the submissions on behalf of Dr Prachalias that he accepted that any lesser sanction than suspension could not be justified given the gravity of the findings against him.

### Conditions

41. The Tribunal next considered whether to impose conditions on Dr Prachalias' registration. It bore in mind that any conditions imposed would need to be appropriate, workable, measurable and proportionate.

42. The Tribunal was mindful of the following paragraph of the Guidance:

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

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

44. The Tribunal considered that it would not be possible to formulate workable conditions in relation to the misconduct found in this case, including in respect of Dr B, where Dr Prachalias' actions occurred outside his practice at a work event. 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

45. Having determined that taking no action or imposing conditions would not be appropriate, the Tribunal went on to consider whether to impose a period of suspension on Dr Prachalias' registration.

46. In doing so, the Tribunal was mindful of the following paragraphs of the Guidance:

*44. ...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.*

47. The Tribunal considered that paragraphs 45(a) and (c) were relevant in this case, indicating that a period of suspension may be the appropriate sanction in the circumstances.

48. The Tribunal had regard to its earlier findings of misconduct in terms of behaviour which represented a serious departure from GMP with a high level of risk. The Tribunal considered that such conduct was capable of undermining public confidence in the

profession and the trust placed in doctors. It fell seriously below the standards expected of a doctor.

## Erasure

49. The Tribunal next considered whether erasure was the appropriate sanction in this case, noting that the Guidance indicated that this may be the proportionate response in the circumstances.

50. In doing so the Tribunal considered the following paragraphs of the Guidance:

*55. Erasure is action available for those cases where a doctor's behaviour, performance, or the impact that a health condition is having on their ability to practise safely and effectively, is incompatible with continued registration at this point in time. It means the level of current and ongoing risk the doctor poses to public protection is so significant that they should not be allowed to practise.*

*56. Erasure takes away a doctor's registration which means they are no longer entitled to practise in the UK at all, or anywhere else where they are required to hold GMC registration. It is used to protect the public in the most serious cases. It also has a deterrent effect as it sends a signal to the individual doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor.*

51. The Tribunal considered that owing to the nature of its findings against Dr Prachalias in relation to Dr B and Dr C, namely sexual harassment and discrimination respectively, it had necessarily identified the risk to public protection as high, in line with the Guidance. However, at the impairment stage the Tribunal had determined that in relation to Dr B, *"whilst inherently serious, the circumstances in this case fell towards the lower end of the spectrum of sexual misconduct."* Whilst it had found that his behaviour was predatory, it found it to be opportunistic as opposed to premeditated or sustained.

52. In relation to Dr C the Tribunal had noted that *"Dr Prachalias admitted his wrongdoing and apologised immediately once it was brought to his attention. He subsequently attended courses on professional boundaries and ethics."*

53. The Tribunal therefore concluded that in respect of sexual harassment and discrimination, Dr Prachalias' actions were serious but did not represent the most serious

type of case and that his actions were not fundamentally incompatible with continued registration. In reaching this conclusion it bore in mind that whilst Dr C was affected by Dr Prachalias' actions, it was a single event for which he immediately apologised and sought to remediate and demonstrate insight. In respect of Dr B, the Tribunal had heard that whilst she was shocked at the time, Dr Prachalias' actions did not have a lasting detrimental effect on her or her ability to practise. The Tribunal also reminded itself of its finding that the risk of repetition was low in respect of Dr A, Dr B and Dr C, but that owing to the incomplete insight demonstrated by Dr Prachalias, an identified risk of repetition nonetheless remained.

54. The Tribunal also considered the following paragraph of the Guidance:

*57. 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.*

55. The Tribunal considered that paragraph 57(a) was applicable, and for the reasons set out previously 57(b) did not apply. It also concluded that 57(c) was not applicable. It had found that Dr Prachalias' demonstrated some insight but it was incomplete and was insufficiently developed, particularly in respect of Dr A and Dr B. The Tribunal had not found that he demonstrated a 'persistent lack of insight'.

56. The Tribunal concluded that Dr Prachalias' actions, whilst serious and requiring a sanction greater than no action or conditions, were not fundamentally incompatible with continued registration. It also concluded that it would not undermine public confidence were he not erased, if an appropriate period of suspension were imposed to mark the seriousness of his departures from the expected standards and to uphold public protection, especially

given his developing insight and his acceptance of the Tribunal's findings and the seriousness of the matters. The Tribunal considered that this was in line with paragraphs 44 and 45 of the Guidance, as set out above.

57. In reaching its decision, the Tribunal noted the submission made on behalf of the GMC that Dr Prachalias *“has shown a persistent lack of insight into the seriousness of the allegations about his behaviour”* in respect of Dr A and Dr B. However, the Tribunal had found that Dr Prachalias had demonstrated some insight, but that this insight was not fully developed and was ‘academic’ in as much as he had not related it to the impact of his own actions or applied his theoretical understanding to the specific circumstances of his own case.

58. In relation to Dr A, the Tribunal determined at the impairment stage that: *“Dr Prachalias’ insight was developing but limited and that his remediation was incomplete.”*

59. In relation to Dr B, the Tribunal had found that: *“Dr Prachalias’ reflections and insight appeared to be a hypothetical and intellectual exercise where he was able to recognise the seriousness of the behaviour and the impact to public protection as a concept. He was however unable to relate that to himself and his actions due to his denial. As such he was unable to demonstrate meaningful insight beyond the conceptual.”*

60. The Tribunal was also mindful of the following paragraphs of the Guidance, as referenced within its determination on impairment:

*89. A doctor has the right to advance a robust defence to an allegation. This includes requiring the GMC to prove their case and bring witnesses to hearings. As a result, an apology may not be forthcoming until after a witness has engaged in the hearing. In other cases, if the defence put forward by the doctor is not successful, it may be unrealistic to expect them to immediately accept every finding, in a fully sincere manner, or apologise.*

*90. However, in these circumstances it may still be possible for the doctor to provide some evidence of insight without them having fully admitted the circumstances of the allegation. Where a doctor gives evidence at a hearing, the MPT will be able to test evidence of insight through oral testimony to assess whether it is genuine.*

61. The Tribunal had concluded that Dr Prachalias had developed insight and remediated in respect of his actions towards Dr C and considered that this, along with the early stages of

insight in relation to Dr A and Dr B, was evidence that he was capable of developing fuller insight and that his misconduct was remediable. It also considered that his acceptance of the findings and acknowledgement that a sanction lesser than suspension would not be appropriate was also indicative of his willingness to demonstrate insight into the seriousness of the findings against him.

62. For all the above reasons, considered in light of the relevant paragraphs of the Guidance, the Tribunal determined that the appropriate and proportionate sanction in this case was that of suspension.

63. The Tribunal also considered the case law submitted by Mr Morris and the submissions made by both him and Ms Fordham in relation to it. The case of *Giele v GMC [2005] EWHC 2143 (Admin)* sets out that “..the existence of a public interest in not ending the career of a competent doctor will play a part.” and “...if erasure is not necessarily required, the skills of the practitioner are a relevant factor.”

64. Mr Morris had submitted that the Tribunal could therefore take into consideration the testimonial evidence provided on Dr Prachalias’ behalf in reaching its decision on sanction. Ms Fordham submitted that the case was from 2005 and that the applicable MPTS Guidance was published in 2025, and so its current relevance was questionable.

65. The Tribunal concluded that although the Guidance was more recent, the principles established in *Giele* were nonetheless relevant and were not at odds with the applicable paragraphs of the Guidance, including those set out by Ms Fordham and Mr Morris in their submissions. The Tribunal noted that it had made the determination that a period of suspension was the proportionate and appropriate sanction and would ensure public protection on the basis of the facts of the case and the applicable paragraphs of the Guidance, independent of the impact of any testimonials. It was satisfied that it could properly apply the principles set out in *Giele* and adopted within the Guidance, especially at paragraph 10, when determining the appropriate length of suspension.

#### Duration of suspension

66. The Tribunal noted that it had received evidence by way of testimonials and patient feedback demonstrating that Dr Prachalias is a highly acclaimed surgeon with rare skills whose expertise is invaluable both to patients and the wider medical profession. Whilst it recognised the value of allowing Dr Prachalias to return to practise, the Tribunal emphasised

that the need to maintain public protection and to reflect the seriousness of its findings was paramount.

67. Dr Prachalias actions in respect of sexual harassment and discrimination were necessarily deemed to be at the higher end of the spectrum of seriousness, and although the Tribunal considered that these were not at the higher end of seriousness for cases of these types there were nonetheless multiple serious findings made against Dr Prachalias. The current and ongoing risk to public protection remained high.

68. The Tribunal considered that whilst it could depart from the indicative sanctions bandings set out in the Guidance, it could not find compelling reasons to do so in this case.

69. Given its earlier findings and the multiple instances of misconduct, the Tribunal determined that a period of suspension less than the minimum 12 months indicated would fail to maintain public confidence or uphold professional standards.

70. Accordingly, the Tribunal determined to suspend Dr Prachalias' registration for a period of 12 months. It was satisfied that this was the balanced and proportionate response in light of all the circumstances, its earlier findings and the applicable guidance.

71. The Tribunal determined to direct a review of Dr Prachalias' 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 Prachalias to demonstrate how he has further developed his insight and remediated his misconduct in respect of Dr A and Dr B.

72. It therefore may assist the reviewing Tribunal if Dr Prachalias provides:

- Evidence of further development of reflection, insight and/or remediation, which includes the expectations of those in leadership roles;
- Evidence of further insight into the specific circumstances of his case with particular regard to the impact upon colleagues and the wider profession;
- Evidence that he has kept his knowledge and skills up to date.

73. Dr Prachalias will also be able to provide any other information that he considers will assist.

#### **Determination on Immediate Order - 21/05/2026**

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

### Submissions

2. On behalf of the GMC, Ms Fordham submitted that in light of Tribunal's findings and the Guidance, an immediate order should be imposed.

3. Ms Fordham submitted that this case where the risk to one or more parts of public protection is high and immediate action is needed to maintain public confidence in the profession, and so an immediate order of suspension is necessary and appropriate.

4. On behalf of Dr Prachalias, Mr Morris submitted that no immediate order is necessary in this case.

5. Mr Morris submitted that the Tribunal found that Dr Prachalias had demonstrated some insight and that period of suspension would be sufficient to mark the seriousness of his departures from the expected standards and to uphold public protection.

6. Mr Morris submitted that there would be no risk to patients were an immediate order not imposed, and so it would be disproportionate and unnecessary to do so. He submitted that the Tribunal should balance the interests of Dr Prachalias and the public of his return to work, considering the exceptional nature of Dr Prachalias' clinical abilities and health treatment for the public.

### The Tribunal's Determination

7. 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.

8. The Tribunal had regard to the paragraphs 83 and 84 of the MPTS Guidance, 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”*

9. The Tribunal considered that given it found the level of risk to public protection to be high and the seriousness of its findings, an immediate order was necessary in the circumstances of this case.

10. The Tribunal determined that it would be inconsistent with its earlier findings to allow Dr Prachalias to practice unrestricted for the appeal period or the duration of any appeal, and would fail to maintain public confidence.

11. The Tribunal was not persuaded that this was outweighed by the submission of Mr Morris that it was in the interests of patients for Dr Prachalias to be allowed to remain in practice.

12. This means that Dr Prachalias’ 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.

13. The interim order currently in place on Dr Prachalias’ registration is hereby revoked.

ANNEX A – 23/03/2026

**Application to Anonymise Witness**

1. At the outset of proceedings, Ms Fordham, counsel on behalf of the GMC, made an application under Rule 35(4) and Rule 36(1) of the General Medical Council ('GMC') (Fitness to Practise) Rules 2004, as amended ('the Rules'), that the identity of one of the GMC witnesses, referred to as Dr B, should not be revealed publicly.

**Submissions**

On behalf of the GMC

2. Ms Fordham submitted that the application was to permit the anonymity of a witness, referred to as Dr B in the allegations and in the witness bundle.

3. Ms Fordham submitted that Dr B is the complainant in respect of allegation 4 which alleges that Dr Prachalias, at a work Christmas party, looked her up and down, grabbed her belt and pulled her towards him and whispered in her ear words to the effect of "*why don't you dress like that more often.*" Later, it is alleged, Dr Prachalias came up behind Dr B while she was dancing and said, "*More, more*".

4. Ms Fordham submitted that allegation 6 alleges that Dr Prachalias' behaviour in respect of Dr B amounted to sexual harassment, was sexually motivated and was an abuse of his more senior position.

5. Ms Fordham submitted that the general discretionary power to permit Dr B to remain anonymous arises from Rule 35(4), and that there is a more specific power in respect of those who are complainants in cases involving sexual allegations arises under Rule 36(1).

6. Ms Fordham submitted that the reasons for this application are that Dr B makes allegations of a sexual nature and she has been permitted under Rule 36(1)(e) to be treated as a vulnerable witness and give oral evidence with Dr Prachalias being required to disable his camera so that she cannot see him and in order to improve the quality of her evidence.

On behalf of Dr Prachalias

7. Mr Morris, counsel on behalf of Dr Prachalias submitted that he had no objections to the application and no comments to make.

### The Tribunal's Decision

8. The Tribunal had regard to the relevant Rules, which state:

*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.*

*36. (1) In proceedings before the Committee or a Tribunal, the following may, if the quality of their evidence is likely to be adversely affected as a result, be treated as a vulnerable witness-*

...

*(e) any witness, where the allegation against the practitioner is of a sexual nature and the witness was the alleged victim; and*

...

*(2) Upon hearing representations from the parties, the Committee or Tribunal shall adopt such measures as it considers desirable to enable it to receive evidence from a vulnerable witness.*

*(3) Measures adopted by the Committee or Tribunal may include, but shall not be limited to-*

...

*(d) use of screens or such other measures as the Committee or Tribunal consider necessary in the circumstances, in order to prevent-*

*(i) the identity of the witness being revealed to the press or the general public; or*

...

9. The Tribunal also had regard to an MPTS Tribunal Circular dated 9 September 2025 which provided an update on the consideration by Tribunals of applications for privacy and anonymity. The Circular states that *“where either party considers that the anonymity of a person is desirable, the party should make a formal application in all cases setting out their reasons pursuant to Rule 35(4).”*
10. In reaching its decision, the Tribunal noted a pre-hearing MPTS Case Management Direction under Rule 16(6)(g) that Dr B is treated as a vulnerable witness and is permitted to give oral evidence with Dr Prachalias having disabled his camera. This decision was dated 27 February 2026 and resulted from an application made by the GMC, which was not opposed by Dr Prachalias’ legal representatives.
11. The Tribunal also considered an email from Dr B dated 10 March 2026 where she states:  
*“I work so hard to reach where I am and be recognise for my work, I am not sure if saying my name will then be associated with this case.”*
12. The Tribunal concluded that Dr B’s evidence was likely to be adversely affected were her identity to be revealed publicly and that allowing anonymisation would enable it to receive the best evidence from Dr B, a vulnerable witness.
13. The Tribunal was satisfied that there would be no unfairness to Dr Prachalias were the application allowed, noting that there were no objections raised on his behalf.
14. Accordingly, the Tribunal determined to grant the GMC’s application.