PUBLIC RECORD

Dates: 08/09/2025 - 22/09/2025

Doctor:	Dr Georgi TSAKOV
GMC reference number:	7006496
Primary medical qualification:	Magister (Physician) 1998 Sofia Medical University

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

Summary of outcome

Erasure
Immediate order imposed

Tribunal:

Legally Qualified Chair	Mr Douglas Mackay
Lay Tribunal Member:	Ms Sarah McAnulty
Registrant Tribunal Member:	Dr Gabrielle Downey

Tribunal Clerk:	Ms Ciara Fogarty

Attendance and Representation:

Doctor:	Not present, not represented
GMC Representative:	Ms Megan Tollit, Counsel
Special Counsel:	Mr Andrew Molloy, Counsel (attended on 08/09/2025)

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts - 15/09/2025

Background

1. Dr Tsakov qualified in 1998 from the Sofia Medical University in Bulgaria. At the time of the events in question, Dr Tsakov was working as a locum consultant dermatologist at the Ashford and St Peter's Hospitals NHS Foundation Trust ('the Trust').

2. The allegation that has led to Dr Tsakov's hearing can be summarised as between 24 February and 3 March 2019, Dr Tsakov was the treating Consultant Dermatologist for Patient C who attended a routine follow up appointment on 3 March 2019. It is alleged that, during the consultation, Dr Tsakov behaved inappropriately towards Patient C.

3. It is further alleged that Dr Tsakov's actions were not clinically indicated, were carried out without Patient C's consent and were sexually motivated.

4. The initial concerns were raised with the GMC on 7 October 2021 by Patient C.

The Outcome of Applications Made during the Facts Stage

5. Ms Megan Tollitt, Counsel for GMC, made an application to the Tribunal under Rule 35(4) of the General Medical Council (Fitness to Practise) Rules 2004. She submitted that the Tribunal may direct that the identity of a witness should not be revealed in public.

6. Ms Tollitt submitted that the Tribunal would be required to hear evidence concerning the complainant's physical health, both as necessary background and as directly relevant to the issues to be determined, namely whether the examinations were clinically appropriate. She submitted that, in view of the nature of the allegations and the sensitivity of the complainant's medical history, it was appropriate for her identity to be anonymised.

7. Accordingly, Ms Tollitt invited the Tribunal to direct that the complainant, whose name appeared in her written witness statement, should be referred to in the hearing as Patient C.

8. The Tribunal granted the application under Rule 35(4) of the General Medical Council (Fitness to Practise) Rules 2004. It determined that, given the nature of the allegations and the relevance of the complainant's physical health, it was appropriate for her identity to be anonymised. In any event there was a statutory prohibition on the publication of information that would lead to Patient C's identity contained within Section 1 Sexual Offences (Amendment) Act 1992. Accordingly, the complainant will be referred to throughout the hearing as Patient C.

9. Ms Tollitt made an application under Rule 34(1) of the General Medical Council (Fitness to Practise) Rules 2004 for the admission of a supplementary statement made by Patient C. She submitted that the statement clarified two discrete aspects of the evidence already described within her original GMC witness statement. Further, the new statement exhibited a two page summary of her police video-recorded interview given in March 2022 as part of her complaint to the police for the same alleged conduct that is the subject of these fitness to practise proceedings.

10. Ms Tollitt submitted that although there had been difficulties in serving the statement on Dr Tsakov, an attempt was made via his registered email address. The statement was also served (with other documents) by special delivery. She submitted that it remained the doctor's responsibility to ensure that the contact details he provided were capable of receiving correspondence. Notification came back that the address did not exist.

11. She further submitted that it was fair to admit the supplementary statement and exhibit not withstanding that it had been made very recently. Further, the evidence contained was relevant to the issues in these proceedings. The evidence was of clarification only and produced following matters that arose in the expert report of Dr D. The alternative was that Patient C could provide her further evidence through supplementary questioning at

the hearing. It was therefore appropriate for the Tribunal to admit the statement and accompanying exhibit, to ensure that the Tribunal had before it all accounts given by Patient C and could consider any inconsistencies when assessing her evidence.

12. Ms Tollitt also applied under Rule 34(1) for the admission of evidence from Mr E, a friend of Patient C to whom in 2021 she first disclosed the matters raised in the allegation. She submitted that the Tribunal and Dr Tsakov had been put on notice at the pre-hearing meeting of 10 June 2025 that the GMC was seeking to obtain his statement.

13. She explained that there had been delay due to the fact that Mr E resides in XXX and does not speak English. His statement requiring the deployment of a XXX interpreter. Two versions of his statement were provided the original XXX and a certified English translation both dated 28 August 2025.

14. Ms Tollitt submitted that the evidence was clearly relevant, going to the complainant's first disclosure of events, and that it would be fair to admit it. She confirmed that, should the Tribunal permit reliance on his evidence, Mr E was available to attend and give evidence with the assistance of an interpreter.

15. The Tribunal granted the application under Rule 34(1) of the General Medical Council (Fitness to Practise) Rules 2004. It noted that issues of admissibility are a matter for the Tribunal, which is both a tribunal of fact and law, and that it is for the Tribunal to determine the weight to be attached to each part of the evidence before it.

16. The Tribunal was satisfied that the supplementary statement and the exhibit had been served to Dr Tsakov's last known registered email and home address. Whilst the doccuments never reached the doctor, it noted that Dr Tsakov had failed to respond to telephone calls, letters, and emails during the course of the proceedings, and the Tribunal made reference to the application to proceed in absence. When that application was made, the Tribunal had considered the issue of service in full. The Tribunal accepted the GMC's submission that Dr Tsakov would not be taken by surprise by the existence of the material as it clarified matters already raised in the case management hearing, the original witness statement and the expert report. Dr Tsakov had ample opportunity to attend the proceedings. The newly served evidence would also be the subject of scrutiny by the Tribunal. Whilst the statements and exhibit would be admitted, the Tribunal would still deliberate on the weight to be given to them.

17. Accordingly, the Tribunal determined that the supplementary statement and exhibit from Patient C should be admitted into evidence.

18. The Tribunal also granted the application under Rule 34(1) for the admission of the statement of Mr E. It accepted that there had been some delay in obtaining the statement, due in part to the fact that he resides in XXX and required the assistance of an interpreter.

19. The Tribunal was satisfied that the statement was relevant to Patient C's first disclosure of the alleged incident, and that it had been served at Dr Tsakov's last known address. It noted that Patient C's account involved sensitive material, but considered that any potential risk of "jigsaw" identification could be managed by the Tribunal. Therefore, the Tribunal determined that it was fair and appropriate to admit the statement into evidence.

20. At the conclusion of the GMC case, Ms Tollitt made an application under Rule 17(6) of the General Medical Council (Fitness to Practise) Rules 2004 to amend particulars of the allegation. It was felt pertinent to do so once the tribunal had heard the oral evidence provided by Patient C. Ms Tollitt reminded the Tribunal that the Rule permits amendment where the facts upon which the allegation is based have previously been notified to the doctor, and where such an amendment can be made without injustice.

21. Paragraph 3(c)(iii) of the allegation had alleged that the doctor "*penetrated her anus with your finger/fingers*." Application was made that in light of clarification provided by Patient C in evidence, the word "penetrated" should be removed and replaced with "touched." Patient C clarified in response to questions from the Tribunal that Dr Tsakov had not inserted his fingers into her anus, but that she had felt them touching her anus. The proposed amendment was therefore to reflect her evidence more accurately.

22. Paragraph 3(d)(iii) had averred that the doctor had undertaken acts "with his fingers." Ms Tollitt also submitted that this too should be amended to "with his finger/fingers," following clarification evidence from Patient C. Patient C said she was uncertain how many fingers were used, and this amendment more accurately reflected her evidence.

23. Ms Tollitt submitted that both amendments were discrete and specific. Their purpose was to ensure that the allegations properly reflected the evidence now before the Tribunal. These issues only arose following clarification given by Patient C in oral evidence this morning, and could not have been anticipated or applied for at an earlier stage.

24. It was submitted that there would be no injustice to the doctor if the amendments were to be allowed. The amendments were consistent with the facts of which the doctor had previously been notified and would not have taken him by surprise had he chosen to attend the hearing. The Tribunal had determined to proceed in his absence, and in those circumstances it was appropriate for the amendments to be allowed.

25. Ms Tollitt submitted that the amendments ensured that the allegations properly reflected the complainant's account, that they were in the interests of fairness, and that they upheld the public interest in ensuring that the charges before the Tribunal accurately represented the concerns raised.

26. The Tribunal granted the application under Rule 17(6). The Tribunal noted that the proposed amendments arose directly from the clarification provided by Patient C in her oral evidence. The allegation in paragraph 3(c) should reflect that the doctor touched, rather than penetrated, her anus. She also confirmed that she was uncertain how many fingers were used, which is more accurately reflected by the wording "finger/fingers" in paragraph 3(d)(iii).

27. The Tribunal determined that no injustice would arise from allowing the amendments. The amendments did not make the Allegation any more serious. The public would expect the allegation to be a reflection of the evidence and the Tribunal considered that justice would be served if it did. It considered that it is in the interests of fairness, and of the public interest, that the Allegation accurately reflect the evidence given.

28. Accordingly, the Tribunal granted the application and directed that the allegations be amended as proposed.

The Allegation and the Doctor's Response

29. The Allegation made against Dr Tsakov is as follows:

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

1. Between 24 February 2019 and 03 March 2019, you were the treating Consultant Dermatologist for Patient [C]. ***To be determined***

2. On 03 March 2019, Patient [C] attended a routine follow up appointment with

you following treatment for malignant melanoma and during the consultation ('the consultation'), you:

a. asked her to undress fully at the beginning of the examination; *To be determined*

b. asked her to undress without respect for maintaining her dignity in that you:

i. positioned yourself to face her; *To be determined*

ii. watched her undress herself fully; *To be determined*

3. During the consultation with Patient [C], you:

a. stroked her:

i. arms*; To be determined*

ii. abdomen; *To be determined*

iii. legs; *To be determined*

b. stood in front of her and touched both of her breasts:

i. with both of your hands; *To be determined*

ii. simultaneously; *To be determined*

iii. in a grabbing motion; *To be determined*

iv. without examining her skin; *To be determined*

c. without explanation of your intended actions conducted an intimate examination of her anus in that you:

i. asked her to lie face down on the examination couch and separate her legs; *To be determined*

ii. pulled her buttocks apart with your hands/fingers; *To be determined*

iii. ~~penetrated~~ touched her anus with your finger/fingers; *To be determined A* Amended under Rule 17(6)

d. without explanation of your intended actions conducted an intimate examination of her vagina in that you:

i. asked her to lie face up on the examination couch and separate her legs; *To be determined*

ii. put both of your hands on either side of her vulva; *To be determined*

iii. with your ~~finger~~ finger/fingers: Amended under Rule 17(6)

aa. stroked her outer labia; *To be determined*

bb. separated her outer labia; *To be determined*

cc. separated her inner labia; *To be determined*

dd. opened her vagina; *To be determined*

ee. on more than one occasion penetrated her vagina; *To be determined*

e. asked her to dress without respect for maintaining her dignity in that you:

i. positioned yourself to face her; ***To be determined***
ii. watched her dress herself fully; ***To be determined***

f. did not maintain hygiene in that you did not change your gloves after the internal examination of her anus and before conducting the examination of her vagina; ***To be determined***

g. failed to examine:
i. the primary site of cancer; ***To be determined***
ii. the regional lymph node basin. ***To be determined***

4. Your actions as set out at paragraph 2. and subparagraphs 3. a-e were sexually motivated. ***To be determined***

5. Your actions as set out at subparagraphs 3. b-d were carried out without Patient [C's] consent. ***To be determined***

6. Your actions as set out at subparagraphs 3. a-d were not clinically indicated. ***To be determined***

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

Witness Evidence

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

- Patient [C], by video link
- Mr E, friend of Patient [C], by video link

31. Dr Tsakov did not produce a witness statement or give oral evidence in the hearing.

Expert Witness Evidence

32. The Tribunal received an expert report from Dr D, Consultant Dermatologist. He also gave oral evidence. Dr D confirmed his qualifications and expertise in dermatology, skin cancer and general dermatological practice. The tribunal accepted that he was qualified to be treated as an expert on the basis of this and could therefore give opinion evidence. Upon

hearing from Dr D, the tribunal was also satisfied that he understood his obligations as an expert witness.

33. Dr D adopted his written statement as his evidence in chief and also gave oral evidence. He stated that at a routine melanoma follow-up appointment the examination would include investigation of the site of the the surgical scar (to determine whether there had been a recurrence) and check of the relevant lymph node basin as a basic minimum. These were the most important aspects of the examination. He said that there would be an examination at the site of the scar and of the groin on the same side for the lymph nodes and that the doctor should feel for lumps. Dr Tsakov's notes of the examination on 3 March 2019 were very brief and recorded only "complex exam normal," with no further detail. Neither the clinical records nor Patient C's account provided evidence of examination of the site of the melanoma and lymph node basin.

34. On Patient C's account, Dr Tsakov required her to undress completely from the outset of the examination, and carried out a full skin/body examination including intimate and internal examinations. Dr D stated that while certain aspects of a full skin check may require close examination (including of the vaginal and anal areas), the alleged requirement for Patient C to remove her clothes fully (including her underwear) at the beginning of the examination was not appropriate. Whilst a full skin/body check is not routinely offered it can be prompted by the patient or if there are concerns about other lesions. If considered it should only be undertaken when it has been fully explained to its purpose and nature and consent from the patient obtained. If it was necessary or if a full skin/body check was requested, Dr D was of the opinion that the removal of underwear should only occur when the relevant body areas fell to be examined.

35. Dr D said that taking the evidence of Patient C, what she described in the doctor's stroking movements of her body was not appropriate. Grabbing her breasts (with one hand on each breast at the same time) was also inappropriate. It was not necessary to touch both breasts at the same time and it was usual to ask consent from the patient to touch her breast.

36. Dr D stated that asking a patient to lie on the bed as described by Patient C was not a recognised part of a full skin/body check. If the natal cleft is to be examined (inside the buttocks) the patient should be asked to lie on their side and draw up their knees. To be asked to lie face down and part her legs as Patient C described is not the usual position and would have been inappropriate.

37. Dr D explained that it is possible to have a melanoma on the anus and the vulva. Examining these areas is guided by concerns raised by the patient or symptoms and is recognised as part of an extended full skin/body examination. However, if a doctor were to undertake this examintion then it should first be explained to the patient and consent sought for it and this should be recorded in a doctor's notes. Repetitive stroking of the vulva and penetration of the anus or vagina is not clinically indicated. Dr D explained that melanoma inside the anus or vagina is possible but very rare and that it is not part of a full skin/body check. Dr D further explained that a melanoma would not be detected by inserting a finger of fingers into the anus or vagina. Such examinations would be inappropriate for a dermatologist to undertake and if they are considered necessary then the patient should be referred to a colorectal surgeon and/or gynaecologist. Dr D reiterated on questioning by the Tribunal that there were no circumstances under which a dermatologist would undertake the examinations as described by Patient C. If Patient C's account as accurate, the described actions were inappropriate, not clinicaly indicated and were conduct that fell seriously below the standard expected of a reasonable competent dermatologist.

38. Dr D noted that no chaperone was documented as having been offered to Patient C. Indeed, Patient C said that one had not been offered to her. He considered that this was inappropriate and fell below expected standards, particularly given the nature of the alleged examination. He also stated that in view of the intimate nature of the examination, Patient C's consent should have been explicitly obtained and documented. If Patient C's account was correct, consent was absent. Consent should have been sought for the touching of the breasts, anus and vagina.

39. Dr D considered the clinical notes sparse and illegible. They were inadequate in that they failed to record the core elements of a melanoma follow-up and did not document whether a chaperone was offered or present.

40. In summary, Dr D stated that certain aspects of the care, including inadequate record-keeping, and failure to offer a chaperone, were below but not seriously below the standard expected of a reasonable and competent dermatologist. However, if Patient C's account was accepted, some of the conduct described, including unnecessary intimate examinations without consent, deploying inappropriate techniques, failing to respect dignity, and hygiene concerns (not changing gloves between the anal and vaginal examinations), and failure to examine the primary site and local lymph notes amounted to care that was seriously below the standard expected of a reasonable and competent dermatologist.

Documentary Evidence

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

- Clinical record of consultation dated 3 March 2019
- Clinical letter dated 15 March 2019
- Clinical letter dated 20 March 2019
- Emails passing between the GMC and Dr Tsakov dated 8-15 November 2021
- Video recording of police interview with Patient C dated 26 March 2022

The Tribunal's Approach

42. In reaching its decision on facts, the Tribunal has taken full account of the statutory overarching objective.

43. It has also borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Tsakov does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e., whether it is more likely than not that the events occurred.

44. The Tribunal were referred to *Re B (Children) [2008] UKHL 35*, where Lord Hoffmann confirmed that serious allegations do not change the standard of proof but do require cogent evidence. The inherent probability of the conduct occurring is a matter to be taken into account.

45. The Tribunal were advised that if, having considered all the evidence, the case is evenly balanced, the GMC will not have discharged its burden and the allegation must be found not proved. They were referred to *Hindle v Nursing and Midwifery Council [2025] EWHC 373 (Admin)*, which emphasises that findings cannot rest on speculation but must be based on cogent evidence sufficient to satisfy the Tribunal on the balance of probabilities.

46. The Tribunal were advised that the GMC's case is put as misconduct namely, sexually motivated misconduct.

47. The Tribunal was advised that it is not necessary for the GMC to adduce corroborating evidence: *Byrne v GMC [2021] EWHC 2237 (Admin*). The Tribunal were also referred to *Roach v GMC [2024] EWHC 1114 (Admin).*

48. The Tribunal were directed that in cases of conflicting accounts, it must first assess whether the complainant's evidence is sufficiently credible. If it is not, the allegation must be dismissed. If it is, it must then weigh it with all the other evidence in deciding whether the GMC has proved its case.

49. The Tribunal was advised to exercise caution against applying stereotyped images of how an alleged victim or an alleged perpetrator of a sexual allegation ought to have behaved at the time, or ought to appear while giving evidence. Instead, the Tribunal is to judge the evidence on its intrinsic merits. Account was to be taken of the fact that people react differently to the trauma of a serious sexual assault; there is no one classic response. A late complaint does not necessarily mean it is a false just as a compliant is not necessarily true just because it is made immediately. The Tribunal was referred to *Roy v GMC (2023) EWHC 2659 (Admin)* and reminded that when assessing credibility in sexual misconduct cases, tribunals must appreciate that it can take a complainant several years to come to terms with events. Further, that many complainants do make a report immediately for a number of reasons which may be linked to trauma, vulnerability, embarrassment, cultural or family pressures.

50. The Tribunal was reminded of the definition of sexual motivation given in *Basson v GMC [2018] EWHC 505*: as conduct undertaken either in pursuit of sexual gratification or of a future sexual relationship. The GMC's case was that the conduct was in pursuit of sexual gratification. They were also referred to *Haris v GMC [2021] EWCA Civ 763*, which confirmed that motivation may be inferred from the nature of the contact, including the fact that touching is of the sexual organs. Further, that an action that was not clinically indicated does not necessarily equate to one which is sexually motivated. Having found the facts in the case, the tribunal would give separate and careful consideration to the issue of sexual motivation.

51. The Tribunal was advised to distinguish between credibility (truthfulness) and reliability (accuracy), and to assess all evidence in the round. It was reminded that witness demeanour is not in itself a reliable guide. Tribunals should acknowledge the fluidity of memory, and should not assess a witness's credibility exclusively on their demeanour when giving evidence: *Dutta v GMC [2020] EWHC 1974 (Admin)*. It was directed to *Joseph v GMC [2022] EWHC 3345 (Admin)* and *Kamran Ali v GMC [2023] EWHC 2984 (Admin)* on careful

evaluation of consistency, discrepancies, and avoiding undue assumptions about truthfulness.

52. The Tribunal was further advised on hearsay and first complaint evidence. It was reminded that such evidence may be admissible and relevant but must be carefully weighed. It was referred to the legal principles arising from sections 114 and 120 Criminal Justice Act 2003 (legislation applicable in criminal law), and the authorities of *R v Athwal [2009] Cr App R 14* and *R v MH [2012] EWCA Crim 770.*

53. The Tribunal was reminded that while experts may give opinion evidence, it is for the Tribunal to decide what weight to attach to it. It is not bound to accept an expert's opinion but must give reasons if they reject it.

54. The Tribunal was advised that they have a discretion to draw adverse inferences under Rule 16A where a doctor has failed to comply with a case management direction. It was referred to *R (Kuzmin) v GMC [2019] EWHC 2129 (Admin), Ramaswamy v GMC [2021] EWHC 1619 (Admin*), and *GMC v Udoye [2021] EWHC 1511 (Admin)*. Any inference must be considered alongside all the evidence, cannot by itself be determinative, and does not reverse the burden of proof.

55. The Tribunal was advised that inadequate clinical notes may be relevant and support an allegation but they cannot alone prove an allegation. It must consider all the evidence and whether there are other reasonable explanations for inadequate notes.

56. The Tribunal was advised that a doctor's good character must be taken into account where relevant. They were referred to *Sawati v GMC [2022] EWHC 283 (Admin),* which sets out the approach to be adopted. In this case the lack of a history of misconduct with a sexual motivation would make it less likely that the conduct occured (propensity). The weight to be given to good character is a matter for the Tribunal. It was further reminded that the significance of good character evidence should not be overstated and must not detract from its primary focus on the evidence directly relevant to the alleged misconduct.

57. The Tribunal was advised that whilst they had heard brief reference to a prior disciplinary finding against Dr Tsakov, it had also been told that it did not concern sexually motivated misconduct. In those circumstances, the Tribunal should still give careful consideration to the relevance and weight of his previous good standing when determining credibility and propensity (particularly in light of no previous findings of sexual motivation).

The Tribunal's Analysis of the Evidence and Findings

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

Analysis of Patient C's evidence

59. The Tribunal began its consideration of the facts by analysing the evidence of Patient C. The Tribunal reviewed her initial report to the GMC in October 2021, her GMC witness statement dated 31 July 2024 , her supplementary statement served in September 2025 which exhibited a summary of her police interview of March 2022 together with her oral evidence before the Tribunal. The Tribunal also had regard to its earlier ruling under Rule 34(1) admitting the supplementary statement and the statement of Mr E, noting that admissibility and weight are separate matters.

60. The Tribunal noted the chronology of accounts: Patient C first reported the matter to the GMC and the police after her conversation with Mr E in August 2021. Her complaint to the GMC followed in October 2021. The date of her report to the police was not clear but she was interviewed (video recorded) by the police in March 2022. She made a statement to the GMC in July 2024, and later produced a supplementary statement which was served, albeit late, in September 2025. The supplementary statement was largely clarificatory and added little by way of substantive detail, beyond exhibiting the police interview summary.

61. The Tribunal considered Patient C's consistency across her accounts and the content of those accounts. Patient C had described being required to undress fully, and she was clear that no chaperone was present. She clarified that she was not asked whether she wanted a chaperone and said that at no time was she asked to consent to the intimate examination of her breasts, anus and vagina.

62. In her statement dated 31 July 2024 she stated that she felt Dr Tsakov examine her breasts, her anus (including internally), and her vagina (including internally).

63. Concerning the examination of her breasts, she said,

"When he was at the front of me, he then touched my breasts with his hands; one hand on each breast. He moved his hands in a grabbing motion when he did this."

64. This was a significant elaboration of what she had said in her initial complaint to the GMC when she briefly wrote,

"He asked me to lift my arms, then he touched them looking for moulds. After, he checked my breast touching them too and he went down to my belly where again he touched me looking for moulds checking with his eyes very closely."

(She clarified in her statement that that she meant "mole" rather than "mould".)

65. Concerning the doctor's examination of her anus, she said in her statement of July 2024,

''He then used both his fingers to pull my buttocks apart. Before he did this, I didn't feel that he examined the outside of my buttocks like he previously and after with the rest of my body, by touching them, and like when he did immediately after when he examined in inside.

I remember that when he pulled my buttocks apart, it was painful. I couldn't see him, but it felt like he also then did an internal examination of my anus, as I felt his fingers in my anus.''

66. This too was significantly more detail than she had provided to the GMC in her initial complaint when she briefly said;

"He introduced his hands between my legs, and he opened my anus, and he said "oh, here you got a cheeky mould"

67. The wording from the July 2024 statement gave rise to the GMC's framing of the allegation averring penetration of the anus. Penetration of the anus had not been referred to in Patient C's initial report to the GMC, and in the summary of her police recorded interview she had simply said;

"He then asked me to move and be face down on the bed, I don't know why but I just did it. I was then told to open my legs, I just did it, he checked my bum, he opened my anus and touched it – he said, "Oh here you have a cheeky mole."

68. The issue of penetration of the anus required clarification and in oral evidence, Patient C clarified that whilst her buttocks were pulled apart and her anus was touched, there was no digital penetration. The Tribunal cross-referred Patient C's oral evidence to that given

in her statement from July 2024. On the face of it there was a direct contradiction that was difficult to reconcile.

69. The Tribunal also considered what Patient C had said in relation to the doctor's examination of her vagina. In her statement from July 2024 she said;

"He then put the fingers of both his hands on my vulva. He had one hand on each side of my vulva. He then used his fingers to separate the inner and outer lips of my vulva apart. After he did this, he used a stroking motion with his fingers again. He stroked up and down both sides of my vulva, about 5 times".

70. In her initial report to the GMC Patient C wrote;

"He introduced his hands between my legs again and he touched my vagina. He separated my external and internal lips, and he examined them very closely."

71. Patient C had included significantly more detail about the vaginal examination in her statement than she had in her initial complaint over two and a half years earlier.

72. The Tribunal referred to the evidence provided by Mr E first complaint. In his statement Mr E recalled that;

"(Patient C) told me that the 'full body check' was very detailed. Dr Tsakov examined her vagina, specifically spreading her labia with his fingers. I recall that she mentioned he asked her to open her legs and that he examined her anus and vagina".

"I believe he examined her whole body, including her breasts, but what I remember, because of how graphic and shocking it was, is that Dr Tsakov asked Patient C to open her legs and examined her vagina and anus."

In oral evidence, Mr E said that he could not recall whether Patient C had provided any further detail.

73. The Tribunal focused very carefully on Patient C's evidence, and in particular the inconsistency around her description of the anal examination, and why what might be considered important detail had not been included in Patient C's original report to the GMC.

The purpose was to assess her credibility and reliability. It took into account what Patient C had said in her statement in July 2024;

"I have been asked by the GMC why this isn't mentioned in my statement at Exhibit [XXX]…
There are several reasons. Firstly, this was hard for me to articulate in a language that isn't my first language; and I thought that it was covered when I said that he 'touched me' there. I also didn't know I had to go in as much detail, and it was painful for me to go even into the amount of detail that I did. It is not because I forgot or that it wasn't important."

74. The Tribunal also took into account Patient C's oral evidence. When asked what she considered the worst part of the examination to be she expressed distress and said that it was the 'whole thing'.

75. The Tribunal considered that the impact of whatever had happened to Patient C in her consultation with Dr Tsakov was clear. In her initial complaint to the GMC she wrote;

"I didn't talk to anyone about it. Not even my partner. I just couldn't.
For some reason I was feeling guilty, responsible. Because I let it happen. Because I didn't say no. Because I was completely shocked that I could not talk.
And I was feeling very embarrassed.
After that, my feelings where very intense on terms of myself.
I was heating myself.
Why did I access to that situation?
Why didn't I left the room?
Why did I open my legs?
Why didn't I ask for a second opinion?
Many questions where in my head.
Too many…
So I started to get bad dreams, panic attacks and anxiety.
The followed months where hell."

76. Mr E wrote in his statement;

"I recall that Patient C said the appointment lasted 10 to 20 minutes. I asked her, words to the effect of, "why did you allow it to happen?"

Patient C said that she was recovering from an illness, specifically skin cancer at the time. Taking into account that Dr Tsakov was a doctor, a person of authority for her, and that he rushed her to give an answer to his offer of a 'full body check- up,' she felt there was pressure for her to go through with it. When she agreed to the 'full body check', she didn't know what the examination would entail."

"I could tell that Patient C was nervous when she was telling me about the incident with Dr Tsakov. She said she felt that if she told someone else about what happened, they would think that she's crazy as a doctor could do examinations to patients. After the examination, she came home and took some time to take everything in. She said that she spent a long time in the shower after she came home from the appointment."

77. The Tribunal was satisfied that Patient C's reaction to what happened explained the original lack of detail in her report to the GMC. Indeed she explained that even those few pages took her 5 days to write. She found that the experience of recounting what had happened in 2019 reopened her feelings of anxiety and distress. Mr E also noted her nervousness. The Tribunal also accepted that her perceived power imbalance between her and the doctor explained why she had acted in the way she did during the examination and after.

78. The Tribunal accepted that the wording in some of Patient C's statements was capable of misinterpretation. It noted that English was not Patient C's first language, and that this may have contributed to the choice/use of words.

79. Following Patient C's clarification of the detail of the anal and vaginal examinations, the allegation was amended (at paragraph 3 c (iii)) under Rule 17(6), to substitute "touched" for "penetrated".

80. The Tribunal also considered the wording of paragraph 3(d)(iii) which referred to "fingers". Patient C gave evidence that she was unsure whether one or more fingers were used during the alleged vaginal examination. The Tribunal was satisfied that the amendment to "finger/fingers" more accurately reflected her evidence.

81. The Tribunal examined whether Patient C had been consistent in her account of Dr Tsakov wearing gloves. In her supplemental statement she said that he was wearing gloves when she was naked:

''I had my pants and bra on and asked do I need to take them off too, the Dr said "YES, EVERYTHING". I was standing in the room and the Dr has approached me, he checked my head putting his hands on both my cheeks and moving my head, he asked me to open my mouth, he was wearing gloves, he check in front of me, touching me, touching my breasts, he checked my belly. He told me to put my arms up, and he moved round to my back, he said "RELAX", I found this creepy, he then put his hands on my shoulders and slid both of his hands down both my arms, he checked my back and bum.''

The Tribunal considered that she did not see him change them during the course of the examination;

'' *I did not see Dr Tsakov change his gloves at any point during the examination.*''

82. In oral evidence Patient C confirmed that he wore gloves throughout and disposed of them afterwards. The Tribunal considered this to be consistent, and there was no suggestion that her evidence was embellished.

83. The Tribunal found that although Patient C's earliest statement to the GMC lacked detail on the most intrusive aspects of the examination, and considered that this was explained by her account of trauma and her coping strategy of initially telling herself that the events 'did not happen'. She described shame, self-blame, and that she had not disclosed the details of what had happened to her partner. The Tribunal placed little weight on her demeanour, but considered that her description of the psychological impact, including her account of how this affected her day to day life was compelling and supported her reliability.

84. The Tribunal accepted that there were inconsistencies between Patient C's first GMC statement and her later oral account, particularly in relation to anal penetration. However, it was satisfied that these inconsistencies were explained and that she was clear in her oral evidence that there was no penetration of the anus. The Tribunal considered that she did not seek to embellish her evidence, and she was fair in acknowledging what she could not remember.

85. The Tribunal noted that Patient C had only met Dr Tsakov on the occasion of her consultation, and it could see no motive for her to fabricate the account. She had disclosed to her friend, Mr E, and later to the police and the GMC. The Tribunal accepted that the statement of Mr E was taken several years after the conversation he recounted and was

served late. It was satisfied that his evidence was supportive only and not determinative, and it placed limited weight upon it.

86. In reaching its assessment, the Tribunal also took into account that Patient C's evidence was consistent with aspects of Dr D's expert report, particularly that the alleged examinations were not clinically indicated in a melanoma follow-up and fell below expected standards.

87. Overall, the Tribunal considered Patient C to be a credible and reliable witness. It found that while there were some inconsistencies between her GMC statement and her oral evidence, these were adequately explained by issues of language, interpretation, and the effects of trauma. Her oral evidence was clear and consistent, and she did not seek to embellish her account. The Tribunal concluded that her evidence could be relied upon in its essential respects.

Paragragh 1

88. The Tribunal considered the contemporaneous clinical documentation, including Dr Tsakov's own clinical letters dated March 2019. It was satisfied from this documentary evidence that Dr Tsakov was the treating Consultant Dermatologist for Patient C during this period.

89. It therefore determined that paragragh 1 of the Allegation is proved.

Paragragh 2

90. The Tribunal considered the evidence of Patient C, including her police interview summary, her GMC statement and her oral evidence. Patient C was consistent across these accounts that she had been asked to undress fully at the beginning of the examination. She further stated that Dr Tsakov was positioned in front of her and watched her undress, and she maintained this consistently in her oral evidence and provided more detail of the layout of the examination room and how the doctor had observed her.

91. The Tribunal noted that Dr D's expert evidence was that patients should only be required to undress to the minimum extent necessary for a clinical examination, and that proper consent and dignity must be maintained. He considered that full undressing, particularly removal of underwear, should only be required when clinically indicated. In this

case, the expert considered the conduct described to be seriously below the standard expected of a competent dermatologist.

92. The Tribunal considered Patient C to be a credible and reliable witness. It accepted her evidence that Dr Tsakov required her to undress fully at the start of the consultation and that he did so without respect for her dignity. The Tribunal considered that Dr Tsakov could have positioned himself differently in order to provide Patient C with privacy and therefore dignity whilst undressing, and that his choice to sit facing her was inappropriate.

93. The Tribunal therefore determined that paragargh 2, including sub-paragraphs (a), (b)(i), and (b)(ii), is proved in its entirety.

Paragraph 3(a)

94. The Tribunal considered Patient C's accounts in her report to the GMC, her statement to the GMC, her police interview summary, and her oral evidence. In her oral evidence she clarified what she meant by "stroking," describing it as Dr Tsakov moving his hand up and down her arms, abdomen, and legs. While her precise use of language varied across her different accounts, the Tribunal was satisfied that what she described amounted to stroking.

95. The Tribunal considered her evidence to be clear, credible, and reliable, and it accepted her description of these actions.

96. It therefore determined that paragraph 3(a)(i)–(iii) is proved.

Paragraph 3(b)

97. The Tribunal considered Patient C's evidence in her statements, in particular to the following:

''I recall him looking at me briefly when he did this. This was the only time that he looked at my face during the whole examination. He then continued with the examination.''

He (Dr. Georgi Tsakov) asked me to get completely undress and to stand in front of him for a "full body check"

''When he was at the front of me, he then touched my breasts with his hands; one hand on each breast. He moved his hands in a grabbing motion when he did this.''

98. The Tribunal had regard to Patient C's oral evidence. She described that Dr Tsakov touched both of her breasts at the same time, using both hands, and in a grabbing motion. She demonstrated the motion that the doctor exercised when doing this. The Tribunal found her evidence to be consistent and credible and was satisfied that these actions occurred as she described.

99. As to sub-paragraph (iv), the Tribunal noted Patient C's account that Dr Tsakov checked her breasts. It also had regard to Dr D's expert evidence that a proper breast examination in a dermatological context would ordinarily be visual, with physical contact limited to instances where a lesion was observed. In light of this, the Tribunal considered that it was possible that Dr Tsakov was examining her skin at this stage (although this may not have been the only thing that he was doing). The Tribunal was not satisfied that the GMC had discharged the burden of proof in relation to sub-paragraph (iv).

100. The Tribunal therefore determined that paragraph 3(b)(i-iii) are proved, and that paragraph 3(b)(iv) is not proved.

Paragraph 3(c)

101. The Tribunal had regard to the amendment made under Rule 17(6), substituting the word "touched" for "penetrated" in sub-particular (iii). Patient C gave clear evidence that while her buttocks were pulled apart and her anus was touched, there was no digital penetration.

102. The Tribunal considered all of Patient C's evidence. It accepted that although earlier wording was capable of being read as suggesting penetration, she clarified the position in her oral evidence. The Tribunal was satisfied that her clarification was credible and reliable, and that her evidence on this matter was consistent when taken in the round.

103. Accordingly, the Tribunal determined that paragraphs 3(c)(i), (ii) and (iii) (as amended) are proved.

Paragraph 3(d)

104. The Tribunal noted the amendment under Rule 17(6) to regularise the wording to "finger/fingers" in sub-particular (iii).

105. The Tribunal considered Patient C's evidence in her GMC statement, police interview, supplementary statement and her oral testimony. In her initial GMC statement, she described Dr Tsakov touching and separating her vulva, but made no reference to stroking, opening, or penetration. In her police account she said that he asked her to lie down, separated both her inner and outer lips, and on more than one occasion separated and opened her vagina. In her supplementary statement she described him putting his hands on her vulva, putting his fingers in her vulva, and stroking her vulva about five times. She also said that he pulled his fingers out about five times.

''He then used his fingers and opened my vagina apart and open. His fingers were on the entrance of my vagina, and he was looking in there. He then put his fingers inside my vagina. I wouldn't be able to say how many centimetres in he put his fingers into my vagina, but it was about the same distance as when you have to take out a menstrual cup. Doing this is a similar sensation to what it felt like when Dr Tsakov inserted his fingers into my vagina; as if looking for something to pull. He inserted, and pulled out and reinserted his fingers like his about five times. He could have done this to stimulate me sexually, but it didn't feel like this. It was painful and felt disgusting.''

106. The Tribunal accepted that there were subtle differences in the terminology she used (for example, between "lips" and "vulva") but considered that in oral evidence she gave a clear, plausible and credible account of what occurred. The Tribunal was satisfied that her description was detailed and consistent when considered across the various accounts, and that her clarification about vaginal penetration was credible.

107. Accordingly, the Tribunal determined that paragraphs 3(d)(i)–(iii)(a)–(e) are proved.

Paragraph 3(e)

108. Tribunal considered Patient C's consistent evidence that as she dressed, Dr Tsakov sat at his desk facing her, with his chair positioned so that he was directly opposite her. She described the layout of the room, stating that he sat with his back against the desk and his hands behind him, which meant that he was facing her as she put her clothes back on. She was confident in this description, and the Tribunal accepted her evidence as credible and reliable.

109. The Tribunal again noted that Dr D's expert evidence was that patients should only be required to undress to the minimum extent necessary for a clinical examination.

''If Patient [C's] allegations and description of her consultation are accurate, then the consultation and examination were seriously below the standard expected of a reasonably competent dermatologist. He is alleged to have asked her to (and watched her) undress and dress in front of him, undress completely at an inappropriate time in the consultation without respect for maintaining her dignity, used inappropriate examination techniques (stroking the skin repeatedly including on her arms, abdomen, legs and vulva), grabbing her breasts while seemingly not actually examining the skin, getting her to lie in uncomfortable and unnecessary positions, conducting internal intimate examinations of the rectum and vagina that were not indicated, conducting intimate internal examinations without consent or explanation, conducting intimate internal examinations in an incorrect manner, not maintaining hygiene by not changing gloves after internal examination. If this is an accurate account of events then this falls seriously below the standard expected of a reasonably competent doctor as he would have failed to obtain adequate consent for an invasive examination, conducted an unnecessary invasive examination which would amount to an assault and failed to respect the patient's dignity.''

110. The Tribunal considered that Dr Tsakov could have positioned himself differently in order to provide Patient C with privacy and therefore dignity, and that his choice to sit facing her was inappropriate. He had chosen to sit on the desk facing her rather than on the chair that was available to him so that he could face away from her. It found that this failed to respect her dignity as she dressed.

111. The Tribunal therefore determined that paragraphs 3(e)(i) and (ii) are proved.

<u>Paragraph 3(f)</u>

112. The Tribunal considered Patient C's evidence that although Dr Tsakov wore gloves throughout the examination, she did not see him change them at any stage and only observed him disposing of the gloves at the end, '*I did not see Dr Tsakov change his gloves at any point during the examination.*'' The Tribunal accepted her account as credible and reliable. However, as Patient C sometimes had her eyes closed, and was face down during the examination of her anus, the tribunal considered that it was possible that the doctor had changed his gloves.

113. On that basis, the Tribunal determined that paragraph 3(f) is not proved.

Paragraph 3(g)

114. The Tribunal had regard to the expert report of Dr D. Dr D stated that:

''At a standard melanoma follow up appointment a clinical examination is usually indicated. Unless the patient declines the examination, a dermatologist would normally examine the site of the original melanoma for signs of local recurrence of disease in or around the scar from treatment. The dermatologist would then normally examine at a minimum the draining lymph node basin, in this case the groin on the same side of the melanoma. Sometimes the contralateral side is also examined for comparison. This examination can be extended to checking other lymph node basins which would include axillae and cervical (neck) areas and the upper abdomen for enlargement of the liver or spleen, depending on the stage of melanoma and degree of suspicion. This is to check for regional or distant spread of the cancer. The dermatologist would then offer to either check specific moles that the patient has concerns about or perform a full skin check. According to the medical notes, Dr Tsakov documented "complex exam normal". The same is expressed in the letter. "Complex" is presumed to mean complete. No further detail is offered. An examination or offered examination as I have described above would be appropriate, but what is documented is not sufficient enough to judge''.

He concluded:

''Regardless of the record keeping, if Dr Tsakov failed to examine the primary site of the skin cancer and failed to examine the regional lymph node basin, this was seriously below the standard expected of a reasonably competent Dermatologist as this is the only essential requirement of this type of clinic assessment. Failure to examine these two areas means no assessment of disease recurrence had taken place. If there were early signs of disease recurrence it may have been missed at a stage where it could have been treatable and the patient come to potentially serious harm.''

115. The Tribunal accepted Dr D's evidence as clear and reliable, and found it consistent with both Patient C's account and the lack of a contemporaneous clinical note (which ought to have recorded the examination of the primary site of cancer and the regional lymph node basin as a bare minimum, and which simply recorded "complex exam normal").

116. The Tribunal therefore determined that paragraph 3(g)(i) and (ii) are proved.

Paragraph 4

117. The Tribunal reminded itself of the definition of sexual motivation set out in *Basson v GMC* [2018] EWHC 505, namely that conduct is sexually motivated if it was done either in pursuit of sexual gratification or in pursuit of a future sexual relationship. The Tribunal noted that the GMC's case was that Dr Tsakov's conduct was undertaken in pursuit of sexual gratification.

118. The Tribunal considered whether there was any plausible clinical explanation for the conduct found proved. It noted that Dr D, in his expert evidence, said that failure to offer a chaperone was below the standard expected of a reasonably competent dermatologist, particularly where intimate examinations were to be performed.

''Failure to offer a chaperone was below the standard expected as one should be offered. If not available this should be explained to the patient and offer for them to come back and be examined at a different time and if they wish to continue this documented in the notes. Not recording anything is not adequate. If Patient [C's] allegation is correct that one was not offered and no explanation is given then this is below the standard expected of a reasonably competent dermatologist. This is not seriously below the standard as it is not uncommon to find yourself in a clinic with insufficient staffing unable to provide a chaperone for every patient examination. Dr Tsakov should still have explained the situation, but given part of the responsibility to provide a chaperone here lies with the department and hospital trust this mitigates this from being seriously below the standard.''

119. Patient C's evidence, which the Tribunal accepted, was that no chaperone was offered despite a nurse being in the vicinity. The absence of a chaperone, when one should have been offered, was considered by the Tribunal to be a factor supporting sexual motivation.

120. The Tribunal also considered that asking Patient C to undress fully at the beginning of the examination, and positioning himself to watch her undress, were actions that were not clinically indicated. Dr D had said that a patient should only be asked to remove clothing as and when necessary, and only for the shortest time possible. The Tribunal found that there

was no clinical need for Patient C to be fully undressed at the outset, and Dr Tsakov's actions in this regard were consistent with sexual motivation.

121. The Tribunal considered the actions in relation to Patient C's breasts. Dr D stated that a proper dermatological examination of the breasts should be visual, with physical contact only where a lesion was seen, and that touching both breasts simultaneously in a grabbing motion was not usual practice. The Tribunal found there was no clinical justification for this conduct, and that it was sexually motivated.

122. In relation to Patient C's anus, the Tribunal accepted that whilst moving the buttocks apart might be clinically indicated in certain circumstances, Dr D stated that had a lesion been identified this ought to have been recorded in the notes for monitoring. There was no such record, and the Tribunal therefore found that this examination of the anus was sexually motivated.

123. In relation to Patient C's vagina, the Tribunal noted that Dr D's evidence was that an internal examination would not be part of a routine melanoma follow-up and was not clinically indicated. The Tribunal found that the actions of separating Patient C's labia and repeatedly stroking and penetrating her vagina with his fingers were inherently sexual and could not be explained by any clinical rationale and the Tribunal therefore found that this examination of the vagina was sexually motivated.

124. The Tribunal further considered that asking Patient C to dress while facing her and watching her put her clothes back on served no clinical purpose and was consistent with sexual motivation.

125. The Tribunal accepted that certain aspects of the conduct, such as moving Patient C's head, were not in themselves indicative of sexual motivation. However, taking the conduct as a whole, the Tribunal was satisfied that the GMC had discharged the burden of proof.

126. The Tribunal considered that the lack of detail in the clinical notes of the examination supported the cogent evidence provided by Patient C and were supporting evidence of a sexual motivation.

127. The Tribunal took account of Dr Tsakov's good character insofar that he did not have a record of adverse findings against him for conduct that was sexually motivated. To that extent, there had not (before the events of March 2019) been a propensity for sexually

motivated misconduct. Nevertheless, this did not detract from the Tribunal's primary focus, which was on the evidence directly relating to the allegation.

128. Having considered whether there was any plausible alternative explanation, and bearing in mind the guidance in Haris that sexual motivation can be inferred from the nature of the touching where it concerns sexual organs, the Tribunal determined that Dr Tsakov's actions as found proved at paragraph 2 and the proved particulars of paragraph 3(a)–(e) were undertaken for sexual gratification.

129. It therefore determined that paragraph 4 is proved.

Paragraph 5

130. The Tribunal had regard to Patient C's consistent evidence that she was never asked for her consent before the intimate examinations were undertaken. She said explicitly that Dr Tsakov did not tell her what he was going to do, nor did he ask her permission. The Tribunal accepted this evidence as credible and reliable.

131. The Tribunal also had regard to Dr D's expert evidence which was that proper practice required the clinician to explain the intended examination and obtain consent, particularly where intimate areas were to be examined. The Tribunal noted that implied consent cannot extend to intimate examinations carried out in the manner described by Patient C. The Tribunal also took into account GMC Good Medical Practise (2013) and Intimate Examinations and Chaperones Guidance (2013) which emphasises the need for explanation and consent.

132. The Tribunal concluded that Dr Tsakov could not have obtained valid consent for the actions found proved, since he did not explain what he intended to do.

133. It therefore determined that paragraph 5 is proved.

Paragraph 6

134. The Tribunal noted Dr D's expert evidence that the actions proved at 3(a) (stroking arms, abdomen, and legs), 3(b) (grabbing both breasts simultaneously), 3(c) (pulling apart the buttocks and touching the anus), and 3(d) (separating the labia and penetrating the vagina)

were not clinically indicated. He stated that these examinations had no clinical justification, particularly as no lesions were identified and no findings were recorded in the notes.

135. The Tribunal accepted Patient C's evidence as credible and reliable. It gave some weight to the evidence of first complaint to Mr E, and it also considered the absence of clinical notes, which was consistent with Dr D's conclusion that the examinations were not indicated. The Tribunal heard no evidence that Dr Tsakov had a history of sexually motivated conduct, but concluded that this was not sufficient to negate the credible and reliable account of Patient C.

136. The Tribunal found the evidence compelling and accepted Dr D's opinion that these actions were not clinically indicated.

137. It therefore determined that paragraph is **proved**.

The Tribunal's Overall Determination on the Facts

138. The Tribunal has determined the facts as follows:

1. Between 24 February 2019 and 03 March 2019, you were the treating Consultant Dermatologist for Patient [C]. ***Determined and found proved***

2. On 03 March 2019, Patient [C] attended a routine follow up appointment with you following treatment for malignant melanoma and during the consultation ('the consultation'), you:
   a. asked her to undress fully at the beginning of the examination; ***Determined and found proved***
   b. asked her to undress without respect for maintaining her dignity in that you:
      i. positioned yourself to face her; ***Determined and found proved***
      ii. watched her undress herself fully. ***Determined and found proved***

3. During the consultation with Patient [C], you:
   a. stroked her:
      i. arms ***Determined and found proved***
      ii. abdomen; ***Determined and found proved***
      iii. legs; ***Determined and found proved***
   b. stood in front of her and touched both of her breasts:

i. with both of your hands; ***Determined and found proved***
ii. simultaneously; ***Determined and found proved***
iii. in a grabbing motion; ***Determined and found proved***
iv. without examining her skin; ***Not proved***

c. without explanation of your intended actions conducted an intimate examination of her anus in that you:
i. asked her to lie face down on the examination couch and separate her legs; ***Determined and found proved***
ii. pulled her buttocks apart with your hands/fingers; ***Determined and found proved***
iii. ~~penetrated~~ touched her anus with your finger/fingers; ***Determined and found proved A*** Amended under Rule 17(6)

d. without explanation of your intended actions conducted an intimate examination of her vagina in that you:
i. asked her to lie face up on the examination couch and separate her legs; ***Determined and found proved***
ii. put both of your hands on either side of her vulva; ***Determined and found proved***
iii. with your ~~finger~~ finger/fingers: Amended under Rule 17(6)
aa. stroked her outer labia; ***Determined and found proved***
bb. separated her outer labia; ***Determined and found proved***
cc. separated her inner labia; ***Determined and found proved***
dd. opened her vagina; ***Determined and found proved***
ee. on more than one occasion penetrated her vagina; ***Determined and found proved***

e. asked her to dress without respect for maintaining her dignity in that you:
i. positioned yourself to face her; ***Determined and found proved***
ii. watched her dress herself fully; ***Determined and found proved***

f. did not maintain hygiene in that you did not change your gloves after the internal examination of her anus and before conducting the examination of her vagina; ***Not proved***

g. failed to examine:
i. the primary site of cancer; ***Determined and found proved***
ii. the regional lymph node basin. ***Determined and found proved***

4. Your actions as set out at paragraph 2. and subparagraphs 3. a-e were sexually

motivated. ***Determined and found proved (excluding in relation to 3 b iv)***

5. Your actions as set out at subparagraphs 3. b-d were carried out without Patient [C's] consent. ***Determined and found proved***

6. Your actions as set out at subparagraphs 3. a-d were not clinically indicated. ***Determined and found proved***

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

Determination on Impairment - 18/09/2025

139. At the conclusion of Stage 1 of these proceedings, the facts stage, Ms Tollitt informed the Tribunal that Dr Tsakov was currently the subject of an existing order imposing conditions on his practice. Ms Tollitt invited the Tribunal to review that matter ('the Review Case'), alongside the impairment and sanction stages of the new hearing, pursuant to paragraphs 21A and 22 of the General (Fitness to Practise) Rules 2024 ("the Rules").

140. The Legally Qualified Chair (LQC) advised the Tribunal that paragraph 21A of the Rules now applied:

> *"(1) If since the previous hearing, a new allegation against the practitioner has been referred to the MPTS for them to arrange for it to be considered by a Medical Practitioners Tribunal, it shall first proceed with that allegation in accordance with rule 17(2)(a) to (j).*
>
> *(2) The Medical Practitioners Tribunal shall thereafter proceed in accordance with rule 22 except that, when determining whether the fitness to practise of the practitioner is impaired and what direction (if any) to impose under section 35D (5),(6), (8) or (12) of the Act, it shall additionally have regard to its findings in relation to the new allegation."*

141. The review case was first considered by a Medical Practitioners Tribunal (MPT) from 5 to 9 July 2021 ('the 2021 Tribunal').

142. The 2021 Tribunal found that on 29 January 2019, during a consultation with Patient A (a different female Patient A to the Patient C in the new proceedings), Dr Tsakov failed to conduct an adequate medical examination. Specifically, the Tribunal accepted Dr Tsakov's admission (and found proved) that he did not explain why the examination was necessary, did not ask Patient A to go behind a curtain to undress, did not invite Patient A to have a chaperone present during the examination, did not offer a gown for Patient A to wear, did not offer Patient A a blanket to cover herself, and did not conduct the examination with Patient A lying on a couch. It was further admitted and found proved that Dr Tsakov undertook an ultraviolet light examination when this was not clinically indicated and was in a normally lit room. It was also admitted and found proved that Dr Tsakov did not explain the rationale for the treatment of Patient A and did not discuss other treatment options with her.

143. Dr Tsakov disputed the part of the allegation that averred that he did not make an adequate record of the consultation with Patient A in that he did not record the history of Patient A's skin disorder, the aggravating factors of the skin disorder, the previous forms of treatment that the patient received, or any clinical findings of his examination. That Tribunal did not find any of these matters proved.

144. The 2021 Tribunal found proved, following Dr Tsakov's admissions, that during a consultation on 24 February 2019 with another female patient (Patient B), Dr Tsakov failed to conduct an adequate medical examination. In particular, he did not examine the affected areas of Patient B's skin, he examined Patient B's legs and groin area despite this not being clinically indicated, and without first explaining why he wished to do so. The Tribunal also found that he undertook an examination of her legs and groin despite this not being clinically indicated and without first explaining to Patient B why he wished to examine her. He undertook an ultraviolent light examination without this being clinically indicated and in a normally lit room. He also admitted that he did not invite Patient B to have a chaperone present. In addition he admitted and it was found proved, that he had failed to maintain adequate communication with Patient B in that he did not discuss how the acne was affecting Patient B, the previous forms of treatment she had received, the outcome of any previous treatment she had received, or any possible factors that might have accounted for the flare up of her acne. Finally, in relation to Patient B, it was admitted and found proved that Dr Tsakov had failed to explain the rationale for his treatment, failed to discuss other treatment options, and failed to make an adequate record of the consultation by not recording the findings of his examination or Patient B's past medical history.

145. The 2021 Tribunal found that Dr Tsakov's conduct in respect of these two patients amounted to serious misconduct which impaired his fitness to practise. That Tribunal directed that conditions be imposed on his registration for a period of 12 months. It also determined that a review was necessary in order to allow Dr Tsakov to develop insight into his misconduct and provide evidence of remediation.

146. Dr Tsakov's case has been subject to regular review since the substantive hearing in July 2021. At a Review of the Papers on 14 October 2021, the Legally Qualified Chair ('LQC') determined that one administrative condition relating to GMC Adviser oversight was inappropriate in a misconduct case and directed its removal. The remaining conditions were continued for a period of 11 months. The ruling does not specifically set out why that course of action was necessary but this had been agreed between the parties and the LQC must have considered that Dr Tsakov's fitness to practise remained impaired.

147. At a Review of the Papers on 20 September 2022, the then LQC observed that Dr Tsakov had not been in clinical practice and was therefore unable to provide workplace evidence of remediation or feedback. His fitness to practise was found to remain impaired, and the conditions in place were extended for a further 12 months.

148. At the Review on the Papers on 19 September 2023, the LQC considered documentation provided by Dr Tsakov. These included a Personal Development Plan (PDP), reflective statements, and certificates from continuing professional development courses (CPD). These materials demonstrated engagement in the review process and some developing insight, particularly in relation to consent, maintenance of dignity, and communication with patients. However, the reviewing LQC concluded that the doctor's insight was incomplete and, in view of his current absence from clinical practice due to XXX, there was no objective evidence of how his remediation was applied in practice. Accordingly, the LQC found that his fitness to practise remained impaired, and the order of conditions on registration were maintained for a further 12 months.

149. At a Review on the Papers on 26 September 2024, the then LQC noted Dr Tsakov's XXX and long-term absence from medical practice. He had been living in Bulgaria and was unable to provide updated PDPs, feedback, or workplace-based evidence of insight or remediation. In those circumstances, the LQC determined that the doctor remained unfit to practice without restrictions and maintained the conditions for a further 12 months.

150. As the September 2024 review was conducted on the papers, the LQC did not have power to direct a further review hearing. The Assistant Registrar therefore issued a direction in November 2024, requiring that a full review hearing be convened before the expiry of the extended order. It was noted that objective evidence of remediation, insight and any return to practice would be expected at the next review.

151. This Tribunal now has to decide, in accordance with Rules 21A and 22, whether Dr Tsakov's fitness to practise is impaired by reason of his misconduct having regard to both the Review Case and its findings in relation to the current Allegation.

The Outcome of the Application to proceed in absence on the review proceedings

152. On behalf of the GMC, Ms Tollitt, Counsel, submitted that the notice of hearing pertaining to the review proceedings had been properly served in accordance with Rules 20 and 40 of the Fitness to Practise Rules 2004. The notice was sent to MDDUS whilst they were instructed to act for Dr Tsakov, and receipt was confirmed on 31 July 2025. Correspondence was sent both to MDDUS and to Dr Tsakov's registered email address. On 12 September 2025, the GMC sent the full review hearing bundle of evidence to Dr Tsakov's registered email address, and although an automated response was received that his mailbox was full, Ms Tollitt submitted that all reasonable steps had been taken to effect service. She reminded the Tribunal of the judgment in *Adeogba v NMC [2017] EWHC 1898 (Admin)*, where it was made clear that the regulator's duty is to communicate at the address provided by the practitioner.

153. Ms Tollitt further submitted that the Tribunal should proceed in Dr Tsakov's absence. Whilst Dr Tsakov had engaged in earlier proceedings, including attendance at the substantive hearing in July 2021, and he had provided documentation supporting his position in previous reviews, there has been no engagement in the new or review proceedings since his representatives ceased to act in August 2025. No explanation has been provided for his absence, and the Tribunal could have no confidence that an adjournment would secure his attendance. In those circumstances, and applying the principles in Jones and Adeogba, it was submitted that Dr Tsakov had voluntarily absented himself and that it was in the public interest for the Tribunal to proceed to determine both the new and review matters in his absence.

154. The Tribunal were advised that the power to proceed in absence derives from Rule 31 of the GMC (Fitness to practise) rules 2004. The Tribunal must be satisfied that all reasonable

efforts have been made to serve the practitioner with the notice of the hearing. The Tribunal was reminded that the principles arising from the cases of Adeogba, Jones and Ramaswamy applied (as they had when the application to proceed in absence was made in relation to the new hearing) and that fairness to the registrant was the prime consideration.

155. The Tribunal accepted the submissions made on behalf of the GMC. It reminded itself that at Stage one of these proceedings it had already determined to proceed in Dr Tsakov's absence in relation to the new fitness to practise matters. The Tribunal was satisfied that service of the notice of hearing had been properly effected in accordance with Rules 20 and 40 of the Fitness to Practise Rules 2004. The Tribunal was now aware from the review bundle of evidence that Dr Tsakov had been XXX and that this was known during the review proceedings. However, Dr Tsakov had not updated this Tribunal with XXX and had not answered any of his correspondence since those representing him came off the record. In the absence of any explanation from Dr Tsakov and having concluded that an adjournment would not secure his attendance in the foreseeable future, the Tribunal determined that it was fair to the doctor, appropriate and in the public interest to proceed with both the new and review matters in his absence.

Background

156. The facts found proved at Dr Tsakov 2021 Tribunal related to his misconduct concerning two patients, Patients A and B. Neither patient was the same as Patient C in the new hearing. The facts found proved are summarised above.

157. Most of the matters averred in the Allegation were admitted by Dr Tsakov from the outset of the hearing in July 2021, and the balance were either found not proved or withdrawn by the GMC. The 2021 Tribunal concluded that in light of the matters proved, the doctor's conduct fell seriously below the standards expected of him, amounted to serious misconduct, and that his fitness to practise was impaired.

158. In sanction, the 2021 Tribunal determined that conditions should be imposed on his registration for a period of 12 months. The Tribunal found that an immediate order imposing conditions was necessary to protect patients and maintain public confidence in the profession.

159. The 2021 Tribunal also identified steps that would assist any future review, including the provision of an up-to-date Personal Development Plan, reflections on the issues found

proved, evidence of supervision, feedback, the completion of CPD courses, and other evidence of insight and remediation.

Evidence and Documents

160. This Tribunal has taken into account all the evidence received during Stage 1 (fact finding) of the new hearing, both oral and documentary.

161. The Tribunal was also provided with additional documents for the review case, including but not limited to the following:

- MPT hearing Record of Determination, dated 7-9 July 2021
- MPT review (ROP) Record of Determination dated 14 October 2021
- MPT review (ROP) Record of Determination dated 20 September 2022
- MPT review (ROP) Record of Determination dated19 September 2023
- MPT review (ROP) Record of Determination dated 26 September 2024
- Various CPD certificates completed by Dr Tsakov dated 2021 to 2023
- Testimonials from two of Dr Tsakov's colleagues dated July 2019

Submissions

Review Case

162. On behalf of the GMC, Ms Tollitt submitted that this is the fifth review of Dr Tsakov's fitness to practise after he was originally found impaired by reason of serious misconduct at the substantive hearing in July 2021. The concerns arose from his treatment of two female patients in January and February 2019, whilst he was working as a locum consultant dermatologist at Ashford and St Peter's Hospital.

163. Ms Tollitt reminded the Tribunal that in relation to Patient A, who attended on 29 January 2019, the Tribunal found that Dr Tsakov failed to conduct an adequate medical examination. He did not explain why the examination was necessary, did not ask the patient to undress behind a curtain, did not provide a gown or covering, and did not invite her to have a chaperone present. Instead, he asked her to remove her trousers in front of him, required her to remove her top, and examined her groin area by asking her to spread her buttocks apart. He also asked her to lower her underwear to the pubic bone before shining a light around her groin area. The Tribunal found that he undertook an ultraviolet light examination despite this not being clinically indicated, and in a normally lit room. It further

found that he failed to explain his rationale for treatment and did not discuss alternative options.

164. Ms Tollitt submitted that in relation to Patient B, who attended on 5 February 2019, the 2021 Tribunal found that Dr Tsakov again failed to carry out an adequate examination. He did not examine the affected areas of skin, but instead examined her legs and groin area despite this not being clinically indicated, and without providing an explanation. He undertook an ultraviolet light examination that was not clinically indicated and in a normally lit room. He failed to invite Patient B to have a chaperone present and did not maintain adequate communication. In particular, he did not discuss how her acne was affecting her, any previous treatment, or possible factors for the flare up. He further failed to explain his rationale for treatment, did not discuss alternative treatments, and did not make an adequate record of his examination findings.

165. Ms Tollitt submitted that the 2021 Tribunal had concluded that the majority of these matters amounted to serious misconduct. Whilst certain individual failings, such as the ultraviolet examinations and some record keeping, were not judged to amount to serious misconduct taken in isolation, the overall pattern of conduct fell far below the standards expected of a registered doctor. At that time, Dr Tsakov's insight was found to be limited, and the 2021 Tribunal concluded that until he developed meaningful insight and took steps to remediate, there remained a risk of repetition.

166. Ms Tollitt submitted that the subsequent reviews, conducted between 2021 and 2024, and Dr Tsakov's failure to engage this year, gave rise to the conclusion that there has been no material change to date. She submitted that the Tribunal will recall that in 2023 Dr Tsakov provided some CPD certificates, a PDP and reflective statements, which the LQC accepted demonstrated some engagement and developing insight. However, that insight was described as incomplete and, crucially, there was no evidence of learning being applied in practice as Dr Tsakov had not worked clinically since 2022. At the 2024 review, the LQC noted that he remained out of practice, living in Bulgaria, and had not provided updated evidence of remediation or learning. His fitness to practise was again found impaired, and conditions were continued.

167. Ms Tollitt submitted that for this present review, no evidence had been provided at all. There were no updated reflections, CPD, PDPs, feedback or testimonials, and since the withdrawal of his representatives in August 2025, Dr Tsakov had ceased to engage with the process. In those circumstances, there was no additonal evidence of any development of

insight, no evidence of remediation, and no basis on which this Tribunal could conclude that the risk of repetition identified in 2021 has been addressed.

168. Accordingly, Ms Tollitt submitted that insofar as the review was concerned, Dr Tsakov's fitness to practise remained impaired by reason of misconduct.

Present Matters

169. Ms Tollitt submitted that Dr Tsakov's fitness to practise is impaired by reason of misconduct in relation to the new matters, and that it remains impaired in relation to the review.

170. She reminded the Tribunal that the decision on impairment is one of judgment for the Tribunal, and there was no of burden or standard of proof. She referred the Tribunal to *Cheatle v GMC [2009] EWHC 645 (Admin),* which established the two-stage approach: First, the tribunal would consider whether the doctor's actions amount to misconduct; and, if so, whether his fitness to practise is impaired as a result. She reminded the Tribunal of *Roylance v GMC (No. 2) [2000] 1 AC 311*, in which misconduct was described as conduct falling short of proper standards, and that the tribunal would need to consider whether misconduct was serious.

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

171. In *Nandi v GMC [2004] EWHC 2317*, misconduct was said to be behaviour regarded as "deplorable" by fellow practitioners.

172. Ms Tollitt submitted that Dr Tsakov's conduct represented a significant departure from Good Medical Practice (2013) ('GMP'). She directed the Tribunal in particular to paragraphs 1, 53 and 65:

1. Patients need good doctors. Good doctors make the care of their patients their first concern: it 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.

53 You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.

65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.

173. The GMC also referred to the 2013 guidance on "Maintaining a Professional boundary between you and your patient", and particularly at paragraphs 3, and 4:

3 Trust is the foundation of the doctor-patient partnership. Patients should be able to trust that their doctor will behave professionally towards them during consultations and not see them as a potential sexual partner.

4 You must not pursue a sexual or improper emotional relationship with a current patient.

174. Ms Tollitt referred the Tribunal to ''Intimate Examinations and Chaperones' (2013), and particularly at paragraphs 5a,c and f:

5 Before conducting an intimate examination, you should:

a. explain to the patient why an examination is necessary and give the patient an opportunity to ask questions

c. get the patient's permission before the examination and record that the patient has given it

…

f. give the patient privacy to undress and dress, and keep them covered as much as possible to maintain their dignity; do not help the patient to remove clothing unless they have asked you to, or you have checked with them that they want you to help.

175. Ms Tollitt submitted that during the consultation with Patient C on 3 March 2019, Dr Tsakov engaged in invasive and sexually motivated behaviour towards a female patient, without consent. This included touching multiple intimate parts of her body (her breasts, buttocks, anus and vagina) and penetrating her vagina with his finger(s) under the guise of an examination. The behaviour was opportunistic, occurred in the context of the inherent power imbalance between doctor and patient, and was found by the Tribunal to be sexually motivated as the conduct was for the purposes of sexual gratification. Patient C described this as sexual abuse and gave evidence of the profound and lasting psychological impact, including nightmares, panic attacks, and anxiety.

176. In addition, Dr Tsakov failed to carry out essential basic elements of a melanoma follow up appointment, namely the examination of the primary site and the regional lymph node basin. Ms Tollit reminded the Tribunal that expert evidence confirmed that this failing could have resulted in early signs of recurrence being missed, exposing the patient to potential serious harm.

177. Taken together, Ms Tollit submitted that this conduct amounted to very serious misconduct.

178. Turning to impairment, Ms Tollitt directed the Tribunal to the test set out by Dame Janet Smith in the Fifth Shipman Report, adopted in *CHRE v NMC & Grant [2011] EWHC 927 (Admin)* and that any of the folliwing features are likely to be present when a doctor's fitness to practise is found to be impaired:

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

Ms Tollitt submitted that the first three apply in this case.

179. Ms Tollitt also reminded the Tribunal of *Cohen v GMC [2008] EWHC 581 (Admin)*, which emphasises that misconduct may or may not be remediable, and that the Tribunal should consider whether it has been remedied and whether it is likely to be repeated. Ms Tollitt submitted that sexually motivated misconduct is not easily remediable, citing *Yeong v GMC (2009) EWHC 1923 (Admin)*, where the High Court noted that efforts to address risks of recurrence in sexual misconduct cases may be of limited significance compared with cases of clinical error.

180. In relation to the review matter, Ms Tollitt reminded the Tribunal that earlier findings concerned two further patients examined in January and February 2019. In both cases, Dr Tsakov failed to conduct adequate examinations, exposed patients bodies unnecessarily, failed to explain rationale or treatment options, carried out ultraviolet light examinations without clinical indication, and failed to offer chaperones. Whilst the case was not put as a sexual motivation case and it was not found as such, these matters nonetheless represented a serious departure from professional standards, and his insight was assessed as limited.

181. Ms Tollitt submitted that although reviews of current impairment noted some engagement through CPD certificates, reflective statements and a PDP, these were described as incomplete and generic. She submitted that more recently, there has been no meaningful engagement at all. The last CPD documents dated from 2022–2023, and the doctor's reflections did not specifically address the proven misconduct. Dr Tsakov had relinquished his licence to practise in March 2025 and ceased to provide any evidence since his representatives withdrew in August 2025.

182. Ms Tollitt submitted that the parallels between the new and review cases are concerning. Within a period of less than three months in 2019, Dr Tsakov engaged in a pattern of conduct requiring female patients to undress for examinations that were not clinically indicated. She submitted that the new matter represented an escalation to overtly sexually motivated behaviour. Taken together, Ms Tollitt submitted that there remains a real risk of repetition.

183. Finally, Ms Tollitt referred to the statutory overarching objective and how the Tribunal might apply the objective to the facts of the review and new case when considering current impairment. She submitted that patient safety had been put at risk, that public confidence in the medical profession had been undermined, and that proper professional standards had not been maintained. To that extent, all three aspects of the overarching objective were engaged and that the tribunal could conclude that Dr Tsakov's fitness to practise was

currently impaired by reason of serious misconduct that was reflected both in the new matter and the matters the subject of the review.

The Relevant Legal Principles

184. The Tribunal was advised that it had already determined at stage one that it was fair and appropriate to proceed in the doctor's absence. Whilst there were some differences in what had been served for the Review hearing, how it had been served and when, the same legal principles applied. The Tribunal was referred to earlier advice provided in the context of the new hearing and the application of the cases of Jones, Adeogba and Ramaswamy. It was now incumbent on the Tribunal to consider whether to also proceed with consideration the review hearing alongside the new hearing in the absence of the doctor and in accordance with Rule 31 of the General Medical Council (Fitness to practise) 2004 ("the rules"). This required an approach in which fairness to the registrant was the prime consideration. If, and only if, it was considered appropriate to proceed with the Review hearing in the absence of the registrant, then the tribunal would go on to consider joinder of the review proceedings with the new case.

185. The Tribunal was directed to Rule 21A and Rule 22 of the rules for practise and procedure regarding the joinder of review proceedings to a new hearing.

186. The Tribunal was advised that there is no statutory definition of misconduct and that misconduct is about behaviour. It could be an act or omission arising in or outside of a doctor's working life and includes failing to act appropriately or demonstrating behaviour that falls short of what can reasonably be expected. To amount to misconduct, the behaviour will be a departure from the professional standards, as set out in Good Medical Practice ("GMP"). GMP is not a set of rules and not every departure from the professional standards will be considered serious. However, if a doctor does seriously depart from the standards, it can mean they pose a current and ongoing risk to public protection. There is no legal definition for the word "serious", and the word should be given its ordinary meaning.

187. The Tribunal was advised to consider the version of Good Medical Practice that was in force at the date of the new Allegation and Review case. In the case against Dr Tsakov, it was the version published in 2013.

188. The Tribunal was advised that in determining impairment it should apply the test endorsed in *CHRE v NMC & Grant* [2011] EWHC 927, and as quoted above (paragraph 37).

189. The Tribunal was reminded of their statutory duty under Section 1 of the Medical Act 1983 to apply the overarching objective: To protect, promote and maintain the health, safety and wellbeing of the public; to promote and maintain public confidence in the medical profession; and to promote and maintain proper professional standards.

190. The Tribunal was further advised that the assessment of current impairment is forward looking. In making that assessment, it should take into account the seriousness of the past misconduct, whether the doctor has developed meaningful insight, whether the misconduct is capable of remediation, whether it has been remedied, and whether there remains a risk of repetition.

191. The Tribunal was reminded of *Cheatle v GMC (2009)* in which Cranston J confirmed that the test for impairment is to be applied in the context of the circumstances at the time and looking forward (at para 22):

"The doctor's misconduct at a particular time may be so egregious that, looking forward, a panel is persuaded that the doctor is simply not fit to practise medicine without restrictions, or maybe at all. On the other hand, the doctor's misconduct may be such that, seen within the context of an otherwise unblemished record, a Fitness to Practise Panel could conclude that, looking forward, his or her fitness to practise is not impaired, despite the misconduct."

192. The Tribunal was also reminded that in In *CHRE v NMC and Paula Grant*, the court also considered the seriousness of past events in looking at the three limbs of the overarching objective) and said (at para 74)

"In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances."

193. Further, in paragraph 32 of the current sanctions guidance it states that;

"…there are some cases where a doctor's failings are difficult to remediate. This is because they are so serious that despite steps subsequently taken, there remains a current and ongoing risk to public protection and action is needed to maintain public confidence"

194. The Tribunal was reminded of *Cohen v GMC* [2008] EWHC 581, which emphasised that misconduct may be remediable, but remediation and insight must be demonstrated. It was also advised that certain forms of misconduct, such as sexual misconduct, are not easily remediable (*Yeong v General Medical Council [2009] EWHC 1923).*

195. The Tribunal was reminded that it was dealing with the Review and new proceedings in the round and that there had been reference to testimonial evidence in the Review proceedings. The two testimonials had already been taken into account by the 2021 tribunal who considered that;

"The Tribunal took into account the two testimonials from Dr Tsakov's colleagues who speak highly of him. However, the Tribunal noted that, neither of these colleagues were in a position to provide objective evidence of his performance and therefore the Tribunal applied limited weight to their evidence. Dr Tsakov also provided feedback forms from patients and colleagues from the period January to April 2021. These were positive but the Tribunal noted they were for a limited period."

The weight to be given to testimonials (if any) was a matter for the tribunal's judgment.

196. The Tribunal was directed that unlike at stage one, there is no burden or standard of proof for this tribunal to apply when considering the issue of impairment. The decision on impairment is a matter for the Tribunal's judgement alone. It is for the tribunal to form their own evaluative judgment as to whether the practitioner's actions fell so far below the standards to be expected of a doctor as to amount to serious misconduct, and whether there was a current and ongoing risk to public protection arising from that.

<u>The Review</u>

197. The Tribunal was advised that in relation to the review, Rule 21A of the Fitness to Practise Rules 2004 applied. Where a review is considered alongside new allegations, the Tribunal must determine both together.

198. The Tribunal were advised that in a review context, the burden of proof does not shift, but there is what has been described as a "persuasive burden" on the doctor to demonstrate that his fitness to practise is no longer impaired. This principle is drawn from *Abrahaem v GMC* [2008] EWHC 183 (Admin). The Tribunal must therefore consider whether the doctor had provided sufficient evidence of insight, remediation, or steps taken to address the concerns identified in 2021.

199. The Tribunal was advised that when assessing the evidence, it should consider the weight to be attached to the testimonials and CPD materials provided at earlier reviews. It may take into account the age of those documents, whether they addressed all of the misconduct that had now been found proved concerning the three patients that had complained, and whether any more recent evidence had been provided.

200. The Tribunal was advised that if it was not satisfied that Dr Tsakov has demonstrated meaningful and up to date insight and remediation, or if the risk of repetition remained current and ongoing, it was entitled to conclude that his fitness to practise remained impaired.

Present Matters

201. The Tribunal was advised that in relation to the new matters, there is no burden of proof when considering misconduct and impairment. It is a matter for their evaluative judgment whether the misconduct if found proved leads to a finding of current impairment.

202. The Tribunal was advised that it should consider whether Dr Tsakov's conduct during the consultation of 3 March 2019, including the findings of sexually motivated behaviour, amounts to serious misconduct. It should consider impairment in the round and taking account of the additional conduct found proved relating to two other patients and their consultations in January and February of 2019.

203. The Tribunal was reminded that it should consider whether the misconduct is capable of remediation, whether there is evidence that it has been remediated, and whether there remains a risk of repetition. It was further reminded that sexual misconduct is regarded as particularly serious and can be difficult to remediate, and that even in the absence of ongoing risk, a finding of impairment may still be necessary to maintain public confidence and uphold proper standards.

204. The Tribunal was advised that the issues required the application of their own judgment. It must determine whether Dr Tsakov's fitness to practise remains impaired in relation to the review case, and if it finds misconduct in the new matters, whether it is also impaired. The Tribunal was reminded to keep the overarching objective firmly in mind.

The Tribunal's Determination on Impairment

Misconduct

205. The Tribunal determined to hear the new case and the review case in accordance with Rule 21(a) of the rules.

Present Matters

206. The Tribunal reminded itself of its findings at the facts stage concerning Patient C's consultation of 3 March 2019. It found that Dr Tsakov required Patient C to undress fully while he remained positioned facing her and that he watched her undress, that he then undertook an examination that included him stroking her arms, abdomen and legs, and inappropriately touching her intimate parts including her breasts, anal and genital areas. This included digital penetration of Patient C's vagina. These actions were carried out without proper explanation, without a chaperone present, and without the patient's consent. The Tribunal also noted that Dr Tsakov positioned himself facing the patient while she dressed herself after the examination. The fact he omitted an examination of the primary melanoma site and regional lymph node basin which were clinically mandated at a melanoma review gave further weight to his actions being sexually motivated. The Tribunal determined that all aspects of his conduct were sexually motivated and not clinically indicated. Indeed, it found that the conduct was predatory, pre-meditated and whilst some of the conduct of the doctor might have been clinically indicated in other circumstances, it was not so indicated in this case.

207. The Tribunal had regard to GMP, it considered that paragraphs 1, 2, 3, 4, 19, 21(a and c), 47, 53, 57, and 65 were engaged.

> *1. Patients need good doctors. Good doctors make the care of their patients their first concern: it 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.*

2 Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or disability.

3 Good medical practice describes what is expected of all doctors registered with the General Medical Council (GMC). It is your responsibility to be familiar with Good medical practice and the explanatory guidance2 which supports it, and to follow the guidance they contain.

4 You must use your judgement in applying the principles to the various situations you will face as a doctor, whether or not you hold a licence to practise, whatever field of medicine you work in, and whether or not you routinely see patients. You must be prepared to explain and justify your decisions and actions.

19 Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.

21 Clinical records should include:

a) relevant clinical findings
…
c the information given to patients

47 You must treat patients as individuals and respect their dignity and privacy.

53 You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.

57 The investigations or treatment you provide or arrange must be based on the assessment you and your patient make of their needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options. You must not refuse or delay treatment because you believe that a patient's actions or lifestyle have contributed to their condition.

65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.

208. The Tribunal also considered the published guidance on "Intimate examinations and Chaperones"(2013), it noted the following paragraphs to be of particular relevance:

5 Before conducting an intimate examination, you should:

a. explain to the patient why an examination is necessary and give the patient an opportunity to ask questions

b. explain what the examination will involve, in a way the patient can understand, so that the patient has a clear idea of what to expect, including any pain or discomfort

c. get the patient's permission before the examination and record that the patient has given it

d. offer the patient a chaperone.

…

f. give the patient privacy to undress and dress, and keep them covered as much as possible to maintain their dignity; do not help the patient to remove clothing unless they have asked you to, or you have checked with them that they want you to help.

6 During the examination, you must follow the guidance in "Consent: patients and doctors making decisions together". In particular you should:

a. explain what you are going to do before you do it and, if this differs from what you have told the patient before, explain why and seek the patient's permission

…

c. keep discussion relevant and don't make unnecessary personal comments.

8 When you carry out an intimate examination, you should offer the patient the option of having an impartial observer (a chaperone) present wherever possible. This applies whether or not you are the same gender as the patient.

13 You should record any discussion about chaperones and the outcome in the patient's medical record. If a chaperone is present, you should record that fact and make a note of their identity. If the patient does not want a chaperone, you should record that the offer was made and declined.

209. The Tribunal further had regard to Maintaining professional boundaries (2013) guidance, paragraphs 3–4:

3 Trust is the foundation of the doctor-patient partnership. Patients should be able to trust that their doctor will behave professionally towards them during consultations and not see them as a potential sexual partner.

4 You must not pursue a sexual or improper emotional relationship with a current patient.

210. The Tribunal considered carefully the expert evidence from Dr D. The Tribunal reminded itself that Dr D explained that whilst aspects of a full skin/body examination may be clinically appropriate during a melanoma follow up examination, such an examination is ordinarily conducted by visual inspection, with palpation confined to identified lesions or clinically relevant areas. It does not require stroking of the arms, abdomen or legs, nor could it justify the grabbing of both breasts in the manner described by Patient C. The Tribunal had further regard to Dr D's expert report:

''If Patient [C's] allegations and description of her consultation are accurate, then the consultation and examination were seriously below the standard expected of a reasonably competent dermatologist. He is alleged to have asked her to (and watched her) undress and dress in front of him, undress completely at an inappropriate time in the consultation without respect for maintaining her dignity, used inappropriate examination techniques (stroking the skin repeatedly including on her arms, abdomen, legs and vulva), grabbing her breasts while seemingly not actually examining the skin, getting her to lie in uncomfortable and unnecessary positions, conducting internal intimate examinations of the rectum and vagina that were not indicated, conducting intimate internal examinations without consent or

explanation, conducting intimate internal examinations in an incorrect manner, not maintaining hygiene by not changing gloves after internal examination. If this is an accurate account of events then this falls seriously below the standard expected of a reasonably competent doctor as he would have failed to obtain adequate consent for an invasive examination, conducted an unnecessary invasive examination which would amount to an assault and failed to respect the patient's dignity.''

211. The Tribunal accepted Dr D's evidence and determined that the doctor's actions, including his methodology that involved stroking the patient's skin, the anal and vaginal examinations found proved were not clinically indicated and represented a marked departure from acceptable clinical practice. The Tribunal accepted this analysis. It considered that the nature of the examinations, the absence of any explanation, the lack of consent for the intimate examinations, the lack of a chaperone, the deficient notes, and the manner in which the doctor watched the patient undress and dress were wholly inconsistent with safeguarding patient dignity and privacy. The Tribunal was satisfied that, taken in the round, the proved actions amounted to assaults carried out under the guise of clinical care.

212. The Tribunal further noted that in her initial complaint to the GMC, Patient C stated: *"I have been a victim of sexual abuse"*. The Tribunal attached particular weight to this contemporaneous account of the impact on Patient C, taken together with Dr D's professional opinion that the conduct found proved amounted to assaults. In the Tribunal's judgment, Patient C's description of her experience was consistent with the expert view that the actions could not be clinically justified. The Tribunal determined that the conduct was gravely serious and deplorable. It represented a serious departure from the standards expected of a registered medical practitioner and from the principles inherent in the overarching objective.

213. The Tribunal attached particular weight to the absence of a chaperone, and to the circumstances in which Patient C was required to undress and dress while Dr Tsakov positioned himself facing her and watching. The Tribunal considered that these circumstances were wholly inconsistent with the dignity, privacy and consent safeguards set in GMP and in Intimate examinations and chaperones guidance. The Tribunal noted the parallels with the earlier pattern of conduct identified in the 2021 determination concerning Patients A and B, where it had also found proved that Dr Tsakov failed to offer a chaperone and failed to provide privacy during undressing. The new matter amounted to an escalation of the doctor's conduct.

214. Taking the conduct in the round, and in the context of the established pattern of conduct that was now apparent from the review case, the Tribunal found the following: the undressing arrangements and absence of chaperone were deplorable; the breast touching, stroking of the arms, legs and abdomen, and anal/vaginal acts were wholly inappropriate, not clinically indicated, and amounted to invasive and degrading examinations; and the failure to examine the primary melanoma site and regional nodal basin constituted a fundamental clinical omission which carried the potential for serious patient harm.

215. The Tribunal reminded itself of its findings at Stage one, that Dr Tsakov's misconduct in respect of Patient C was sexually motivated. It found that his actions were not undertaken for any legitimate clinical purpose but were self-serving, premeditated and designed to secure sexual gratification under the guise of a clinical examination. The Tribunal considered that Dr Tsakov deliberately took advantage of Patient C's vulnerability as a young woman attending for cancer follow up, exploiting the inherent imbalance of power between doctor and patient. It determined that this conduct was both abhorent and deplorable. In the Tribunal's judgment, sexual misconduct of this nature represents a most serious departure from the standards of professional behaviour expected of a doctor.

216. The Tribunal also considered the CPD materials and reflections. It noted that these documents were not provided by Dr Tsakov for the present hearing but had been included by the GMC from material submitted at earlier reviews. While they demonstrated that Dr Tsakov had undertaken some online courses, the accompanying reflections were generic in nature and did not sufficiently address the specific misconduct found proved. The Tribunal rejected the doctor's explanation that his own experience as a patient had caused him to reflect on the importance of professionalism, considering this to be inconsistent with the totality of conduct now proved.

217. The Tribunal observed that the complaint arising from the examination of a patient in March 2019 was the third occasion within a two to three month period during which Dr Tsakov had required female patients to undress without proper justification or safeguards, and had failed to offer a chaperone. His reflections failed to acknowledge that he had a significantly important obligation to ensure a chaperone was present for intimate examinations as required.

218. The Tribunal further noted that earlier reviewing tribunals had already considered these same CPD certificates and reflections in September 2023 and September 2024. On both occasions, those tribunals concluded that the documents demonstrated only limited

insight and remediation and that Dr Tsakov's fitness to practise remained impaired. In the present case, the Tribunal agreed with those assessments. It considered that the reasons put forward by the doctor for not offering a chaperone for the first two patients (contained within his written reflections submitted to the 2023 Review Tribunal) underlined the absence of genuine insight. The Tribunal was satisfied that, taken in the round, the lack of meaningful CPD engagement and inadequate reflection further underscored the seriousness of his misconduct.

219. The Tribunal was satisfied that the conduct taken as a whole represented a serious departure from GMP and from the ethical requirements in the GMC's guidance on intimate examinations and chaperones. Having also found that the conduct was sexually motivated, the Tribunal considered the serious misconduct to amount to a high level of seriousness. In the round, the Tribunal determined that all aspects of the Allegation that had been found proved amounted to serious misconduct.

Review of previous misconduct

220. The Tribunal reminded itself of the original findings of misconduct made in July 2021 concerning Patients A and B. Those patients were seen in January and February 2019. Of particular concern were the findings that Patient B was asked to expose her legs and groin and was examined with an ultraviolet lamp in a normally lit room, without any clinical justification and without explanation. These actions were admitted by Dr Tsakov and found proved.

221. Whilst not going behind the findings of the July 2021 Tribunal, the current Tribunal considered that the conduct now seen as a whole showed a pattern of behaviour that demonstrated a flagrant disregard for patient dignity and privacy, and for the professional obligation to ensure proper consent and safeguards during intimate or potentially sensitive examinations. In its 2021 determination, that Tribunal described Dr Tsakov's failure to offer a chaperone as a clear departure from expected standards. In the present hearing, when considering the review case alongside the new matters, the Tribunal placed these failings in context. It noted that this was the third occasion within a two to three month period when Dr Tsakov required female patients to undress without appropriate explanation, safeguards, or the presence of a chaperone.

222. The Tribunal further noted that the September 2023 and September 2024 reviews on papers had already considered these same CPD certificates and reflections and had

concluded that they demonstrated only limited engagement, and that Dr Tsakov's fitness to practise remained impaired. In the present hearing, the Tribunal reached the same conclusion. It determined that the absence of up-to-date CPD or evidence of genuine reflection, when considered against the repeated nature of the misconduct in 2019, underlined the absence of meaningful remediation and the continuing seriousness of the misconduct. The doctor had not engaged in the new proceedings and therefore had not provided any insight or remediation into the matters that gave rise to a finding of sexual motivation.

223. Accordingly, the Tribunal was satisfied that the misconduct in relation to Patients A and B, when taken together with the more serious conduct found proved in relation to Patient C in March 2019, amounted to a pattern of behaviour that was gravely below the standards expected of a registered doctor.

Impairment

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

225. The Tribunal also considered the CPD materials and reflections. While they showed some engagement with online courses, the accompanying reflections were generic, contradictory, and failed to address the specific misconduct found proved. His explanation that his own experience as a patient had caused him to reflect on professionalism was inconsistent with the factual findings, and in the Tribunal's view, demonstrated limited or indeed absent insight.

226. The Tribunal gave no weight to the testimonials provided in July 2019. They were now over six years old, they addressed the January and February 2019 conduct but not the March 2019 conduct, they were prepared without knowledge of the March 2019 (complaint had not been made at that time), and as already determined by the 2021 tribunal, they only carried limited weight then.

227. The Tribunal, in considering whether Dr Tsakov's misconduct was potentially remediable, concluded that where there was a significant, repeated and sustained pattern of behaviour. It would be difficult to remediate this conduct without a substantial development of insight. The Tribunal was mindful of its Stage one findings that Dr Tsakov's actions had

been premeditated, deliberate and repeated, and that they had been sexually motivated. His conduct was self-serving and opportunistic, taking advantage of the inherent power imbalance between doctor and patient. The Tribunal determined that such behaviour breached fundamental tenets of the profession and represented a grave departure from the standards expected of doctors as set out in GMP. The Tribunal further had regard to the authority of *Yeong v GMC [2009] EWHC 1923 (Admin),* which emphasised that sexually motivated misconduct by doctors is particularly serious and not easily remediable. The Tribunal found that his conduct in March 2019 was of so serious a nature that it could not be remediated.

228. The Tribunal noted that while certain clinical omissions might in theory be remediable, the misconduct proved in this case was of a fundamentally different nature. The Tribunal had already found that Dr Tsakov's actions were sexually motivated, self-serving and predatory. He deliberately chose not to have a chaperone present, exploited the clinical setting, and used the guise of a medical examination to pursue sexual gratification.

229. The Tribunal noted that Patient C was a woman with a history of a melanoma which is a serious diagnosis, and the consequences of his behaviour for her were both psychological and clinical. The Tribunal considered her account, in which she described feeling partly to blame and referred to the incident as sexual abuse, as well as Dr D's clear evidence that the conduct amounted to assault. It determined that the behaviour was gravely serious and not remediable.

230. The Tribunal considered this misconduct in the context of a series of consultations that amounted to escalating serious misconduct. This was the third incident in a period of two to three months in early 2019, following similar failings regarding privacy and dignity with Patients A and B in the review case. The Tribunal found that Dr Tsakov has shown no insight into the sexual motivation underpinning his actions and has provided no explanation as to why they occurred.

231. The Tribunal considered the four features that might be present when a doctor's fitness to practise is found to be impaired. Those features are those arising from the fifth Shipmasn report and as referred to in *CHRE v NMC & Grant [2011] EWHC 927 (Admin):*

> *a. The Doctor Has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b. Has in the past and/or is liable in the future to bring the medical profession into disrepute; and/or
c. Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or
d. Has in the past acted dishonestly and/or is liable to act dishonestly in the future.

It found that in respect of factor (a), Dr Tsakov's conduct had placed Patient C at unwarranted risk of harm. By failing to examine the primary melanoma site and regional nodal basin, there was a real possibility that early signs of recurrence could have been missed, exposing Patient C to potentially serious consequences.

In respect of factor (b), Dr Tsakov's conduct had clearly brought the profession into disrepute. His actions towards Patient C, including intimate examinations found to be sexually motivated, were described by her in her original complaint as sexual abuse, and were plainly liable to undermine public trust in doctors.

In respect of factor (c), Dr Tsakov had breached fundamental tenets of the profession, including the obligation to respect patient dignity, maintain professional boundaries, obtain consent, and act with integrity. These are core duties under GMP, and the Tribunal found they were repeatedly and deliberately breached.

232. Accordingly, the Tribunal found that factors (a), (b) and (c) in *Grant* were engaged. This was not a case involving dishonesty and the tribunal felt that factor (d) did not apply.

233. The Tribunal then went on to consider whether there was any evidence before it of insight or remediation on the part of Dr Tsakov and whether there was a current and ongoing risk of the conduct being repeated in the future.

234. In line with the authorities of Cohen and Grant, the Tribunal found that all three limbs of the overarching objective were engaged:

(a) protecting patients; Given the Tribunals findings of serious clinical failures combined with high level sexual misconduct towards a patient, the Tribunal found there was a significant risk of repetition and a current and ongoing risk to patient safety.

(b) maintaining public confidence; Dr Tsakov's conduct had clearly brought the profession into disrepute. His actions towards Patient C, including intimate examinations found to be sexually motivated and were plainly liable to undermine public trust in doctors.

(c) promoting proper standards; Dr Tsakov behaviour had breached fundamental tenets of the profession, including the obligation to respect patient dignity, maintain professional boundaries, obtain consent, and act with integrity. These are core duties under GMP, and the Tribunal found they were repeatedly and deliberately breached.

The Tribunal found that the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in these circumstances.

235. Furthermore, in the absence of any evidence from Dr Tsakov relating to insight or remediation arising from the Tribunal's findings, the Tribunal had nothing before it to satisfy it that such conduct would not occur again in the future. Accordingly, there remained a high risk of repetition of the misconduct.

236. The Tribunal concluded that Dr Tsakov's actions in the new matter represented an egregious breach of trust, at the most serious end of the spectrum of professional misconduct. The Tribunal determined that Dr Tsaov's fitness to practise is impaired by reason of his misconduct.

The Review Case

237. The Tribunal reminded itself of the overarching objective and that there is no burden or standard of proof at the impairment stage; the question is a matter for the Tribunal's judgment. The Tribunal also noted that in a review case, there is a "*persuasive burden*" on the practitioner to satisfy the reviewing Tribunal that they are safe to return to unrestricted practice.

238. The Tribunal reminded itself of the sanction imposed by the 2021 Tribunal and the subsequent reviews, the last being in September 2024. At that stage, conditions were imposed, including requirements for reflective work and personal development plans. The Tribunal at that review found that Dr Tsakov's fitness to practise remained impaired because little had changed in terms of remediation or insight, even though he was then still engaging with the process.

239. The present Tribunal noted that the same position had continued. Dr Tsakov has failed to address the issues previously identified, has not complied with the requests of earlier reviewing tribunals to provide meaningful evidence of remediation, and had disengaged from the process altogether. He had not provided any CPD or evidence of reflection since 2023, and had relinquished his licence to practise.

240. The Tribunal determined that the current concerns could not be viewed in isolation from the two earlier patients. Further, that the review of impairment concerning the findings arising from the complaints from the patients in the review case had to be seen now in the context of the findings in the current case. There are clear parallels between the misconduct proved in 2021 concerning Patients A and B and the new matter now before the Tribunal. All involved inappropriate or unnecessary examinations, failures to offer chaperones, and failures to respect patient dignity. Little had changed since the last review, there is no new evidence of remediation, no objective evidence of CPD, and no demonstration of insight. The Tribunal therefore concluded that the risk of repetition remains high and that Dr Tsakov's fitness to practise continues to be impaired by reason of misconduct.

Conclusion

241. The Tribunal considered all the evidence before it in both the review and the new case. It reminded itself of its Stage one findings in respect of Patient C and the finding of sexually motivation. That conduct was self-serving, deliberate, and predatory in nature. He exploited the clinical setting, deliberately chose not to have a chaperone present, and used the guise of a medical examination to pursue acts for his sexual gratification. The Tribunal considered this to be a flagrant abuse of the inherent power imbalance between doctor and patient and conduct that put Patient C's health at risk. She had a melanoma removed. In her oral evidence Patient C described suffering from a panic attack when she next had to visit that same hospital for an unrelated reason.

242. Whilst at earlier reviews Dr Tsakov had submitted limited CPD and evidence of reflection, this were generic and failed to address the core misconduct that had been found. He has provided no further evidence since 2023, has now disengaged entirely from the process, and has not therefore addressed the findings of sexual motivation. The Tribunal determined that taken in the round, this absence of engagement and the contradictions within his earlier reflections showed a lack of insight and an absence of remediation.

243. The Tribunal considered that the sexual misconduct proved in this case is, by its nature not remediable. It represented a grave breach of fundamental tenets of the profession, patient dignity, integrity, and trust. The Tribunal further noted the pattern of repeated misconduct within a short period in 2019, encompassing three separate female patients, which underlined the high risk of repetition.

244. Taking all of these matters into account, the Tribunal concluded that Dr Tsakov has demonstrated no insight into his sexual misconduct, has failed to remediate it, and poses an ongoing and serious risk to patient safety, public confidence in the profession, and the maintenance of proper standards.

245. The Tribunal concluded that a finding of impairment is necessary to protect, promote and maintain patient safety, to maintain public confidence in the medical profession, and to uphold proper professional standards and conduct for members of that profession.

246. The Tribunal has therefore determined that Dr Tsakov's fitness to practise is impaired by reason of serious misconduct for the present case, and it remains impaired by reason of serious misconduct in the Review Proceedings.

Determination on Sanction - 22/09/2025

247. Having determined that Dr Tsakov's fitness to practise is impaired by reason of misconduct, the Tribunal now has to decide, in accordance with Rules 21A and 22 of the Rules, the appropriate sanction, if any, to impose for both the Review case and the new case.

The Evidence

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

Submissions

249. On behalf of the GMC, Ms Tollitt submitted that the appropriate sanction in this case was one of erasure.

250. Ms Tollitt referred the Tribunal to the Sanctions Guidance (the 'SG') (2024). She referred the Tribunal to paragraphs 14, 16 and 17. At paragraph 14, the guidance confirms that the principal purpose of sanctions is to protect the public, pursuant to the overarching statutory objective. At paragraph 16, it is stated that sanctions are not imposed to punish doctors, though they may have a punitive effect. Paragraph 17 makes clear that the reputation of the profession is more important than the interests of an individual doctor.

251. Ms Tollitt referred the Tribunal to *The General Medical Council v Dr Maher Khetyar [2018] EWHC 813 (Admin)* where the High Court emphasised that the Sanctions Guidance provides an authoritative steer on proportionality. While tribunals may depart from that steer, they must do so only with careful, case specific justification and generalised assertions will not suffice.

252. Ms Tollitt submitted that the Tribunal should apply paragraphs 20 and 21 of the SG, which require consideration of all sanctions starting with the least restrictive, applying the principle of proportionality, and imposing the minimum sanction necessary to protect the public.

253. Turning to mitigating features, Ms Tollitt submitted that paragraph 25(b) of the SG allows weight to be given to previous good character. It was submitted that this factor did not apply here, as this was a review following an earlier finding of misconduct and the context of the new hearing was that it was made in the context of a previous finding of misconduct for the doctor. Paragraph 25(b) also refers to the need for a doctor to keep up to date, but the Tribunal had heard that Dr Tsakov had been out of practice for several years and relinquished his licence to practise in March 2025. Paragraph 25(e) refers to a lapse of time between an incident and a sanction and how that can be a mitigating feature. It was submitted that whilst the incidents occurred in 2019, their seriousness was not diminished by delay. As to paragraph 25(a), it was submitted that the Tribunal had already found that the doctor's previous reflections on his conduct were generic, contradictory and failed to address the proved misconduct, and no up to date evidence had been provided for this review and new case. There was therefore no evidence of genuine insight or remediation.

> *25 The following are examples of mitigating factors.*
>
> *a Evidence that the doctor understands the problem and has insight, and of their attempts to address or remediate it. This could include the doctor admitting facts relating to the case, apologising to the patient (see paragraphs 42–44), making*

efforts to prevent behaviour recurring, or correcting deficiencies in performance or knowledge of English.

b Evidence that the doctor is adhering to important principles of good practice (ie keeping up to date, working within their area of competence), and of the doctor's character and previous history. This could include evidence that the doctor has not previously been found to have impaired fitness to practise by a tribunal, a previous MPTS panel or by the GMC's previous panels or committees.

…

e Lapse of time since an incident occurred

254. Turning to aggravating features, Ms Tollitt submitted that paragraphs 51–55 of the SG were clearly engaged. There was a complete lack of insight, a previous finding of impairment, an abuse of professional position and sexual misconduct. She referred to paragraphs 142–143 of the SG, which underline that doctors must not exploit their position for sexual or emotional purposes, and paragraphs 149–150 of the SG, which state that sexual misconduct involving patients is likely to result in more serious action, such as erasure.

255. Ms Tollitt reminded the Tribunal of its findings on impairment that Dr Taskov's conduct was predatory and premeditated. She referred to paragragh 68 of its Impairment determination:

'' The Tribunal reminded itself of its findings at the facts stage concerning Patient [C's] consultation of 3 March 2019. It found that Dr Tsakov required Patient [C] to undress fully while he remained positioned facing her and that he watched her undress, that he then undertook an examination that included him stroking her arms, abdomen and legs, and inappropriately touching her intimate parts including her breasts, anal and genital areas. This included digital penetration of Patient [C's] vagina. These actions were carried out without proper explanation, without a chaperone present, and without the patient's consent. The Tribunal also noted that Dr Tsakov positioned himself facing the patient while she dressed herself after the examination. The fact he omitted an examination of the primary melanoma site and regional lymph node basin which were clinically mandated at a melanoma review gave further weight to his actions being sexually motivated. The Tribunal determined that all aspects of his conduct were sexually motivated and not clinically indicated. Indeed, it found that the conduct was predatory, pre-meditated and whilst some of the conduct of the doctor

might have been clinically indicated in other circumstances, it was not so indicated in this case.''

She reminded the Tribunal of its finding that Dr Tsakov's conduct amounted to sexual assaults under the guise of clinical care, and represented an egregious breach of trust. The Tribunal had also found that it could not be remediated. She noted that in addition to the sexual misconduct, Dr Tsakov failed to carry out essential melanoma follow up examinations, exposing Patient C to a risk of potentially serious harm.

256. Ms Tollitt submitted that lesser sanctions were not appropriate. Taking no action or inviting undertakings were plainly inappropriate. Conditions were not workable or proportionate in the context of serious sexual misconduct and in light of the Dr Tsakov's disengagement.

257. Ms Tollit referred the Tribunal to the relevant pargarghs of the SG regarding suspension. She reminded the Tribunal that suspension was reserved for cases where the conduct, though serious, was not fundamentally incompatible with continued registration. She submitted that here, the conduct was irredeemable, there was no acknowledgement of fault, and the Tribunal had found an established pattern of behaviour.

258. Turning to erasure, Ms Tollitt relied on paragraphs 108–109 of the SG, which confirm that erasure may be necessary even in the absence of ongoing risk to patient safety, where required to maintain confidence in the profession and protect the public. Ms Tollitt submitted that paragrahs 109(a),(b)(c)(d)(f)(j) were engaged:

> *109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).*
>
> *a A particularly serious departure from the principles set out in Good medical practice where the behaviour is difficult to remediate.*
>
> *b A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.*
>
> *c Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients.*

d Abuse of position/trust

…

f Offences of a sexual nature, including involvement in child sex abuse materials.

j Persistent lack of insight into the seriousness of their actions or the consequences.

259. In conclusion, Ms Tollitt submitted that Dr Tsakov's conduct towards Patient C was gravely serious and deplorable. Taken against the background of a previous finding of misconduct, she submitted that the conduct was fundamentally incompatible with continued registration. The only proportionate sanction, and the only one capable of upholding all three limbs of the overarching objective, was one of erasure.

The Tribunal's Approach

260. The Tribunal was reminded that the decision as to the appropriate sanction, if any, was a matter for the exercise of its own judgement.

261. The Tribunal was advised to have regard to the Sanctions Guidance, and to give case-specific reasons for any departure from that guidance. This included, but was not limited to, the paragraphs on which counsel for the GMC had relied.

262. The Tribunal also bore in mind that the purpose of a sanction is not to be punitive, albeit that a sanction may have a punitive effect.

263. It further reminded itself that, in determining whether to impose a sanction and if so, which, the Tribunal should have regard to the principle of proportionality and should consider the available sanctions in ascending order, i.e. start by considering the least restrictive option.

264. The Tribunal was advised that proper adherence to the Guidance is required. In *GMC v Saeed [2020] EWHC 830 (Admin)* the Court confirmed that: "Tribunals must have proper regard to the SG and, if departing from it, must provide clear and sound reasons."

265. The Tribunal was advised that it must balance the public interest against the doctor's interests. In *Yusuff v GMC [2018] EWHC 13 (Admin*) the Court emphasised that findings of fact from the original hearing cannot be reopened at review, that sanctions are not imposed to punish though they may be punitive in effect, and that once a sanction is deemed necessary to protect the public, it must be imposed even if it causes significant hardship to the doctor.

266. The Tribunal must also weigh aggravating and mitigating factors, and consider any evidence of insight and remediation.

267. The Tribunal was reminded that in serious misconduct cases such as predatory sexual behaviour, personal mitigation will carry limited weight. In *R (O'Connor) v Police Misconduct Panel [2023] EWHC 2892 (Admin)*, the Court observed that an unblemished record is the norm in disciplinary proceedings, and its weight is limited when balanced against public interest. Similarly, in *GMC v Robert Stone [2017] EWHC 2534 (Admin)*, it was confirmed that personal mitigation carries less weight in a regulatory context than in criminal sentencing.

268. The Tribunal was reminded that in *GMC v Narayan [2017] EWHC 2695 (Admin),* the Court stressed that any departure from the SG must be fully explained with reference to the relevant paragraphs, and that tribunals must consider all three limbs of the overarching objective without placing disproportionate emphasis on one limb.

269. The Tribunal was reminded that insight requires timely acceptance of wrongdoing, evidence of empathy, and genuine attempts at remediation. Where misconduct is particularly serious, remediation may not be sufficient to protect the public or maintain public confidence.

270. The Tribunal was directed to *GMC v Rezk [2023] EWHC 3228 (Admin),* in which the Court emphasised that tribunals must identify aggravating and mitigating factors at sanction, and specifically address the impact of misconduct on victims and on public confidence. In *Yeong v GMC [2009] EWHC 1923 (Admin)*, Sales J noted that in cases of sexual misconduct, personal efforts at remediation may carry limited weight where public confidence requires a firm declaration of standards.

271. The Tribunal must ensure that the sanction imposed is appropriate and proportionate, but also that it adequately protects the reputation of the profession, which is more important than the interests of any individual doctor.

272. The Tribunal was advised that in *PSA v GMC and Hanson [2021] EWHC 588 (Admin),* the Court stressed that tribunals must consider the overall seriousness of the conduct. Where there is a calculated and deliberate abuse of power causing foreseeable harm, the registrant poses a danger to the health, safety and wellbeing of the public, unless there is a clear basis for concluding that the conduct will not be repeated.

The Tribunal's Determination on Sanction

Aggravating factors

273. Before considering what action, if any, to take in respect of Dr Tsakov's registration, the Tribunal considered the aggravating and mitigating factors that were present in the Review case and new case when taken in the round.

274. The Tribunal found a number of significant aggravating features.

275. The Tribunal noted the following paragraphs of the SG:

> *31 Remediation is where a doctor addresses concerns about their knowledge, skills, conduct or behaviour. Remediation can take a number of forms, including coaching, mentoring, training, and rehabilitation (this list is not exhaustive), and, where fully successful, will make impairment unlikely.*
>
> *32 However, there are some cases where a doctor's failings are difficult to remediate. This is because they are so serious that despite steps subsequently taken, there remains a current and ongoing risk to public protection and action is needed to maintain public confidence. This might include where a doctor knew, or ought to have known, they were causing harm to patients and should have taken steps earlier to prevent this.*
>
> *33 In such serious cases, the tribunal must fully and clearly explain:*
>
> *a the extent to which the issues can be remediated*

b the steps the doctor has taken c how the seriousness of the findings – including the doctor's failure to take steps earlier – justifies the tribunal taking action, notwithstanding the steps subsequently taken.

34 Doctors may present references and testimonials to support their good standing in the community or profession. The tribunal should consider what weight, if any, to give to these documents.

35 During preparation for the hearing, doctors are notified that the GMC will confirm to the tribunal whether the testimonials have been verified (are authentic and the authors are aware of the fitness to practise proceedings and the allegations that the doctor faces). Tribunals will consider all relevant factors, including those set out in paragraph 39, but they are likely to place greater emphasis on testimonials that have been verified.

36 If a doctor is represented by a solicitor, their solicitor can provide assurance at any point up to and including submission of the testimonials that they have undertaken appropriate verification.

55 Aggravating factors that are likely to lead the tribunal to consider taking more serious action include:

…

d abuse of professional position, particularly where this involves:
i vulnerable patients
ii predatory behaviour

e sexual misconduct

31. The Tribunal had regard to paragraphs 142–148 of the SG relating to abuse of professional position. The Tribunal determined that these paragraphs were engaged, as Dr Tsakov exploited the inherent imbalance of power in the doctor–patient relationship for his own sexual gratification.

276. The Tribunal determined that there had been no meaningful development in insight or remediation since the 2021 hearing. Although some CPD activity was undertaken in the Review case, it was not directed to the concerns found proved in the new case, and Dr

Tsakov had since disengaged entirely from the regulatory process. He had provided no substantive evidence of insight, remediation or reflection, and his email apology from November 2021 following the lodging of the new case complaint was limited to an apology for "any inconvenience caused" and demonstrated a lack of appreciation of the seriousness of the alleged conduct.

277. The Tribunal found that the misconduct towards Patient C in the new case was particularly serious. Patient C was a vulnerable woman, XXX, with a previous cancer diagnosis, who was entitled to trust Dr Tsakov to examine her appropriately for recurrence of her melanoma and to keep her safe. Instead, he abused that position of trust, coercing and manipulating her, and dismissing her concerns in a manner the Tribunal found belittling and intimidating. The Tribunal found that his conduct involved a significant abuse of power, and amounted to predatory behaviour.

278. The Tribunal considered that Dr Tsakov's level of seniority and experience aggravated the seriousness of the misconduct. He had been practising as a consultant in the UK and the hospital for nearly a year at the time of the events, and ought to have been well aware of expected professional standards for consultants. His senior position meant that Patient C placed a high level of trust in him, which he exploited for sexual gratification.

279. The Tribunal noted that there was evidence of escalation in the seriousness of his conduct relating to the patients that had previously complained and the new complaint by Patient C. Taken together, the misconduct formed part of a pattern of behaviour (as found at stage two). Insofar as the new case was concerned, this included predatory and premeditated actions amounting to sexual assaults under the guise of clinical care.

280. The Tribunal also considered the impact of the conduct towards Patient C in the new case. She described panic attacks, sleeplessness, feeling intimidated, and she avoided medical care as a consequence of what had happened to her. This had a deterrent effect on her willingness to attend hospital, notwithstanding the potentially life threatening implications of her melanoma diagnosis. The Tribunal accepted this evidence of significant and lasting harm.

281. The Tribunal further noted that an ongoing police investigation into the matters was a relevant contextual factor, although it was not determinative as no conclusions had yet been reached by the police as to how to take the investigation further.

Mitigating factors

282. As to mitigating factors, the Tribunal took account of the SG at paragraphs 24 to 49.

283. The Tribunal noted that the 2021 Tribunal recorded that, prior to the events of 2019, Dr Tsakov was of previous good character. Up until that time, there were no concerns raised about his professional practice. To that extent, the tribunal felt that his good character up to 2019 carried some weight in its sanction determination as it was now considering the new and review cases in the round.

284. The Tribunal accepted that there had been a lapse of time between the events in question and the making of the complaints, with a delay of a few weeks before the first allegations were reported and a longer delay for Patient C in the new case. However, the Tribunal found that the lapse of time attracted limited weight in mitigation given the seriousness of the conduct, the fact that Dr Tsakov had not reported himself and that this resulted in delay, and that his lack of engagement in the Review case had also contributed to delay.

285. The Tribunal noted that, in relation to the review matter, Dr Tsakov had undertaken some CPD activity and provided reflections, but these were considered of limited weight as they did not address the core misconduct. There was therefore only very limited insight and remediation and this applied only to the Review case. The Tribunal noted that the conduct in the new case (Patient C) could not be remediated.

286. In relation to both the review and new matters, the Tribunal recorded that Dr Tsakov had not provided any testimonials. The earlier testimonials provided in 2019 were made prior to the current allegations and accordingly carried no weight.

287. The Tribunal noted that Dr Tsakov had apologised in a limited way for the review case and had only acknowledged receipt of Patient C's complaint. He had admitted the conduct found proved in the Review case. Some credit was due to him for his admissions but this was not considered to amount to meaningful insight or remediation.

288. The Tribunal also accepted that Dr Tsakov had not been in clinical practice in recent years due to XXX and had relinquised his licence to practise.

Available sactions in ascending order

No action

289. The Tribunal first considered whether to conclude the case by taking no action. The Tribunal determined that there are no exceptional circumstances in this case which would warrant the taking of no action in the context of the facts found proved and the Tribunal's determination on impairment. It considered that the taking of no action would not be sufficient, proportionate, or in the public interest.

Conditions

290. The Tribunal next considered whether to impose conditions on Dr Tsakov's registration. In so doing, it bore in mind that any conditions imposed would need to be appropriate, proportionate, workable, and measurable. It had regard to paragraphs 79-90 of the SG.

291. The Tribunal determined that conditions were not appropriate. Dr Tsakov had previously been subject to conditions, which he failed to fulfil, and he had since relinquished his licence to practise. He was therefore not able to comply with any conditions that might be imposed.

292. The Tribunal noted that the concerns identified in this case could not be remediated by conditions. In relation to the review matter, Dr Tsakov had not demonstrated sufficient insight, and the Tribunal was not satisfied that he would comply with or respond to conditions in the future. In relation to the new matter, the Tribunal determined that the misconduct could not be remediated at all.

293. The Tribunal further determined that conditions would not be sufficient to protect the public, satisfy the public interest or maintain public confidence in the profession in light of the seriousness of the misconduct.

294. Accordingly, the Tribunal determined that no appropriate or workable conditions could be formulated.

Suspension

295. The Tribunal next considered whether it would be appropriate and proportionate to suspend Dr Tsakov's registration.

296. The Tribunal first noted paragraph 93 of the SG:

> *93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions*

297. The Tribunal determined that Dr Tsakov had provided no meaningful acknowledgement of fault, and his misconduct showed a pattern of escalating behaviour. The Tribunal found that the conduct occurred in a clinical setting and demonstrated an escalating pattern of behaviour. He continued to pose a significant risk of repetition given his lack of insight and the fact that his behaviour was not remediable.

298. The Tribunal next considered SG paragraph 97, namely factors which, if present, may indicate that suspension is appropriate. It had regard to the following sub-paragraphs:

> *'97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*
>
> *a A serious departure from Good medical practice, but where the misconduct is not so difficult to remediate that complete removal from the register is in the public interest. However, the departure is serious enough that a sanction lower than a suspension would not be sufficient to protect the public.*
>
> *b In cases involving deficient performance where there is a risk to patient safety if the doctor's registration is not suspended and where the doctor demonstrates potential for remediation or retraining.*
>
> *…*
>
> *e No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.*

f No evidence of repetition of similar behaviour since incident.

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

299. In summary, the Tribunal concluded none of the above sub-paragraphs mitigated in favour of suspension. The sexually motivated conduct in the new case was not remediable. Suspension would not be sufficient to protect the public. Whilst there has been no evidence of repetition since March 2019, all of the proved misconduct had been in a clinical setting and the doctor had not been in clinical practice since 2021.

300. In all the circumstances, the Tribunal determined that suspension would not meet the overarching objective of protecting the public, nor would it maintain confidence in the profession or uphold proper standards.

Erasure

301. The Tribunal next considered whether erasure was the appropriate sanction. The Tribunal went on to consider paragraphs 107 and 109 SG:

'107 The tribunal may erase a doctor from the medical register in any case – except one that relates solely to the doctor's health and/or knowledge of English – where this is the only means of protecting the public.

108 Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.'

302. The Tribunal determined that the following provisions of paragraph 109 were engaged:

109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).

a A particularly serious departure from the principles set out in Good medical practice where the behaviour is difficult to remediate.

b A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.

c Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients

d Abuse of position/trust

e Violation of a patient's rights/exploiting vulnerable people

f Offences of a sexual nature, including involvement in child sex abuse materials
…
i Putting their own interests before those of their patients

j Persistent lack of insight into the seriousness of their actions or the consequences.

303. The Tribunal determined that Dr Tsakov's misconduct was of the utmost seriousness. His conduct in the new case involved predatory and premeditated sexual assault under the guise of clinical care, representing an escalating pattern. Combining the new and the review case three patients were involved, and all were exposed to harm, and for Patient C particularly, the potential harm, was significant. Patient C also described lasting psychological and emotional effects arising from the doctor's conduct, including avoidance of medical care, panic attacks, and sleeplessness. The Tribunal considered that the doctor's conduct would be regarded as deplorable by fellow professionals.

304. In reaching this conclusion, the Tribunal had regard to the authorities. In *Yeong v GMC* [2009] EWHC 1923 (Admin), Sales J held that in cases involving sexual misconduct, personal mitigation may carry limited weight where a firm declaration of professional standards is required to uphold public confidence. In *GMC v Stone* [2017] EWHC 2534 (Admin), the Court confirmed that personal mitigation carries less weight in regulatory proceedings than in criminal law. The Tribunal also noted *PSA v GMC and Hanson* [2021] EWHC 588 (Admin),

which emphasised that in cases involving a deliberate abuse of power causing foreseeable harm, erasure is the appropriate sanction unless there is a proper basis for concluding that the conduct is unlikely to be repeated. The tribunal felt that each of these authorities were applicable and did not seek to depart from the principles arising.

305. The Tribunal determined that Dr Tsakov's behaviour engaged multiple factors in the SG which indicated that erasure is appropriate, and that the seriousness of his misconduct could not be addressed by any lesser sanction.

306. In reaching its decision, the Tribunal reminded itself of the statutory overarching objective.

307. In line with the authorities of Cohen and Grant, the Tribunal found that all three limbs of the overarching objective were engaged:

(a) protecting patients; Given the Tribunals findings of serious clinical failures combined with high level sexual misconduct towards a patient, the Tribunal found there was a significant risk of repetition and a current and ongoing risk to patient safety.

(b) maintaining public confidence; Dr Tsakov's conduct had clearly brought the profession into disrepute. His actions towards Patient C, including intimate examinations found to be sexually motivated and were plainly liable to undermine public trust in doctors.

(c) promoting proper standards; Dr Tsakov behaviour had breached fundamental tenets of the profession, including the obligation to respect patient dignity, maintain professional boundaries, obtain consent, and act with integrity. These are core duties under GMP, and the Tribunal found they were repeatedly and deliberately breached.

The Tribunal found that the need to uphold proper professional standards and public confidence in the profession would be undermined if it did not determine that erasure was the appropriate sanction.

308. The Tribunal determined that erasure was the only sanction capable of adequately protecting the public, maintaining public confidence, and upholding professional standards.

309. The Tribunal therefore determined to erase Dr Tsakov's name from the medical register. In the review case the power to erase is within section 35D (12) (a). In the new case the power to erase being within section 35D (2)(a).

Determination on Immediate Order - 22/09/2025

310. Having determined that Dr Tsakov's name should be erased from the medical register, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether her registration should be subject to an immediate order.

Submissions

311. On behalf of the GMC, Ms Tollitt submitted that an immediate order is necessary both to protect the public and that it would also otherwise be in the public interest. She directed the Tribunal to paragraphs 172, 173, 177 and 178 of the SG.

The Tribunal's Determination

312. In reaching its decision, the Tribunal considered the relevant paragraphs of the SG and exercised its own independent judgment. In particular, it took account of paragraphs 172, 173 and 178:

> '*172* *The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. …*
>
> *173* *An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.*
>
> …
>
> *178* *Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive direction*

being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect.'

313. The Tribunal reminded itself of its finding that Dr Tsakov's conduct was most grave in nature. His actions in March 2019 had involved what might be considered to be a penetrative assault, and his conduct was found to amount to a pattern of escalating misconduct that included deficient clinical practice and a sexual motivation. It noted there were three women effected and insofar as the incident in March 2019 was concerned, the impact on Patient C was profound. The Tribunal reflected on its findings at the sanctions stage and took account of the aggravating and mitigating features of the Review case and New case taken in the round.

314. The Tribunal gave full consideration to the overarching objective and determined that, given the seriousness of Dr Tsakov's misconduct and the sanction imposed, it is in the public interest to suspend his registration with immediate effect. This was necessary to maintain public confidence in the profession. Further, it was necessary to protect the public, maintain patient safety, and maintain proper professional standards and conduct for members of the profession. The Tribunal was of the view that public confidence would be undermined if Dr Tsakov was permitted to practise unrestricted, given its finding that his conduct was incompatible with continued registration.

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

316. The conditions currently imposed on Dr Tsakov's registration will be revoked when the immediate order takes effect.

317. That concludes this case.

ANNEX A – 15/09/2025

SERVICE AND PROCEEDING IN ABSENCE

Service:

318. Dr Tsakov is neither present nor represented today. The tribunal is invited by the GMC to proceed with this new Fitness to Practise hearing in the absence of the Doctor.

319. The Tribunal first considered whether the relevant documents had been served on Dr Tsakov in accordance with the General Medical Council (Fitness to Practise Rules) 2004 (The Rules) and Schedule 4, paragraph 8 of the Medical Act 1983 as amended ("The Act").

Submissions

320. Ms Megan Tollitt, Counsel on behalf of the GMC provided a bundle of material pertaining to Service of the notice of this hearing and otherwise evidencing the extent to which Dr Tsakov has engaged in these proceedings. Other material that was relevant to the issue of notice and knowledge of these proceedings was also contained in two previously served bundles. This material included but was not limited to:

- Screenshots of the contact information held for Dr Tsakov by the GMC, namely his registered postal address and email address
- GMC Work Details Form
- Email correspondence between GMC and Dr Tsakov regarding XXX dated 15 November 2021
- MPTS Case Management meeting records relating to pre-hearing meetings on 19 March 2025 and 10 June 2025.
- The MPTS Notice of hearing correspondence sent to Dr Tsakov, dated 31 July 2025
- Dr Tsakov's legal representative's at MDDUS acknowledgement of the Notice of hearing from the MPTS, dated 31 July 2025
- Email from MDDUS informing the MPTS they are no longer representing Dr Tsakov dated 19 August 2025
- Draft hearing bundle, sent by special delivery post to Dr Tsakov at his registered address dated 29 August 2025

321. Ms Tollitt submitted that notice of the hearing has been served in accordance with the Rules. The Tribunal was taken to the updated proof of service bundle, which included confirmation of Dr Tsakov's registered address in Bulgaria, his registered e-mail address, and telephone contact numbers.

322. Ms Tollitt submitted that Dr Tsakov had corresponded with the GMC during the course of the investigation, most recently in October 2024, and that he was legally represented by MDDUS until August 2025. At the case management meeting in June 2025, Dr Tsakov's representative confirmed that she was instructed to accept service on his behalf and subsequently confirmed receipt of the Notice of Hearing on 31 July 2025.

323. Ms Tollitt further submitted that following MDDUS' withdrawal, the GMC and MPTS continued to send correspondence directly to Dr Tsakov at his registered address and by email. Although some more recent attempts had resulted in an automated "mailbox full" response and returned postal correspondence, it remained the practitioner's responsibility to maintain up to date contact details.

324. Ms Tollitt referred the Tribunal to the judgment in *GMC v Adeogba [2016] EWCA Civ 162,* noting that the GMC's duty is limited to serving notice at the address provided by the practitioner. Ms Tollitt submitted that this duty had been discharged and that service had therefore been achieved.

325. Ms Tollitt submitted that, in light of the evidence within the bundle and Dr Tsakov's failure to engage further, the Tribunal had the power to proceed in his absence.

326. In the circumstances, the Tribunal was satisfied that notice of this hearing has been served in accordance with the relevant provisions. The Tribunal went on to consider whether to proceed in Dr Tsakov's absence pursuant to Rule 31.

Proceeding in Dr Tsakov's absence

327. Ms Tollitt submitted that, if the Tribunal was satisfied that service had been properly effected, it should exercise its discretion under Rule 31 of the Rules to proceed in Dr Tsakov's absence. She reminded the Tribunal that the relevant considerations were set out in *R v Jones [2002] UKHL 5*, including whether the practitioner had voluntarily absented themselves, whether an adjournment would be likely to secure their attendance, the likely

length of any adjournment, whether the practitioner wished to be represented, and the extent of any disadvantage arising from their absence.

328. Ms Tollitt submitted that the discretion to proceed must be exercised with great care and caution, balancing fairness to the practitioner with fairness to the GMC and the public, and taking account of the statutory overarching objective. She referred the Tribunal to GMC v Adeogba [2016] EWCA Civ 162, noting that whilst the criteria in criminal proceedings are relevant, they must be considered within the different context of regulatory proceedings.

329. Ms Tollitt submitted that Dr Tsakov had previously engaged with the GMC, had corresponded by e-mail in 2021 and 2024, and had engaged legal representation until August 2025. At a case management meeting in June 2025, his representative stated they would accept service on his behalf and confirmed the hearing dates. However, from around that time, Dr Tsakov ceased engaging with the process. His representative subsequently withdrew due to lack of instructions, despite repeated attempts to contact him via all known addresses, digital communication links and telephone numbers. Counsel submitted that there had been no further explanation for Dr Tsakov's non-attendance, XXX.

330. Ms Tollitt submitted that, given the absence of any recent engagement, it was open to the Tribunal to conclude that Dr Tsakov had voluntarily absented himself from these proceedings. Ms Tollitt further submitted that an adjournment would not be likely to secure Dr Tsakov's attendance, as his current whereabouts were uncertain, his registered address appeared unreliable, and his email account was no longer functioning. In those circumstances, the Tribunal could not have confidence that his position would change in the near future.

331. Ms Tollitt submitted that the case involved serious allegations of misconduct which had been under investigation for some time, and that Dr Tsakov was fully aware of the concerns since 2021. He had been provided with the hearing bundle and had every opportunity to respond.

332. The Tribunal raised that there was reference within Patient C's (the complainant) referral to the GMC that she had also reported the matter to the Police. The Tribunal was concerned as to whether any criminal investigation or legal proceedings had concluded and particularly whether such investigation or proceedings should take precedence. Ms Tollitt informed the tribunal that the police investigation into the same matters remained pending but without active enquiries or any clear timeframe for progress. It was submitted that the

GMC proceedings should not be left indeterminate pending a criminal process that may not progress in the foreseeable future.

333. Ms Tollitt submitted that fairness to the complainant, who remained willing to give evidence, and the wider public interest, required that the hearing proceed without further delay. Ms Tollitt emphasised that the Tribunal must balance fairness to Dr Tsakov against the need to protect patients, maintain public confidence, and uphold professional standards, and submitted that those considerations favoured proceeding in his absence.

334. Ms Tollitt informed the Tribunal that the doctor had voluntarily relinquished his licence to practise.

The Tribunal's Decision

335. The Tribunal had regard to Rule 31, the statutory overarching objective and the relevant caselaw, namely, the cases of *R v Jones [2001] QB 862*, ("Jones"), and *GMC v Adeogba [2016] EWCA Civ 162*, ("Adeogba"), *Ramaswamy v GMC [2021] EWHC 1 6 19 (Admin)* ("Ramaswamy")

336. The Tribunal was further advised that disciplinary hearings differ from criminal trials, as emphasised by Lord Justice Leveson in Adeogba. The efficient and expeditious disposal of regulatory cases is vital to uphold the overarching objective, and registrants are under a duty to engage with their regulator. Where there is no good reason for absence, proceedings should not be frustrated by delay.

337. On the relationship between regulatory and criminal proceedings, the Tribunal was advised that there is no firm rule that criminal proceedings must take precedence. The two processes are separate and serve different purposes. There are different standards of proof that apply. The Tribunal may adjourn to await the outcome of criminal proceedings if appropriate, for example to avoid prejudicing a police investigation or evidence, but it is not obliged to do so. Relevant considerations include:

- whether criminal proceedings are likely to conclude within a reasonable timeframe;
- the length of delay already incurred;
- that the potential sanction in criminal proceedings is far more serious than in regulatory proceedings and that in most circumstances the criminal proceedings would take precedence for that and other reasons;

- the impact of delay on complainants and witnesses;
- the factual complexity of the case;
- whether evidence has already been preserved;
- the extent to which the fairness of subsequent criminal proceedings might be impacted by further delay;
- whether proceeding would create satellite issues that might adversely affect criminal proceedings (including but not limited to a suggestion that the regulatory proceedings had rehearsed the witnesses, disclosure of unused material, the publication of the outcome of the regulatory proceedings).
- whether the practitioner is engaging with either process; and
- the public interest in avoiding indeterminate delay, public expecation that the overarching objective will be upheld.

338. The Tribunal was reminded that the decision whether to proceed in absence is for it alone, and reasons for its decision must be clearly recorded.

339. The Tribunal carefully balanced Dr Tsakov's interests (in particular fairness) with the public interest in deciding whether to proceed in his absence.

340. The Tribunal took account of the principles outlined in Jones and Ramaswamy, particularly regarding fairness, and the right to a fair trial as outlined in the European Convention of Human Rights. It also took account of the over-riding objective to deal with cases failrly and justly taking precedence over the over-arching objective to protect the public, and that fairness to the registrant is the prime consideration.

341. The Tribunal noted that Dr Tsakov has long been aware of the investigation and of the hearing. He engaged for a period, including through legal representatives who, at the preliminary hearing on 10 June 2025, confirmed they were instructed to accept service and indicated no difficulty with producing a statement from the doctor within 6–7 weeks. Representation ceased on 19 August 2025. Since then, there has been no further engagement and the Tribunal has no reliable independent information as to the reasons for his non-attendance. The Tribunal noted regarding previously referrenced XXX has been provided by the doctor.

342. The Tribunal noted that the GMC and MPTS have made multiple attempts to contact Dr Tsakov via e-mail, telephone and post (to his last known address in Bulgaria to where he had returned). Emails had generated "mailbox full" messages and post to the registered

address has been undeliverable. In those circumstances, the Tribunal has no confidence that an adjournment would secure his attendance or improve the doctor's engagemement with the proceedings in the foreseeable future. It noted that Dr Tsakov has had every opportunity to attend, be represented, provide a written statement, or notify the tribunal of reasons for his absence; he has not done so notwithstanding the setting of enforceable legal directions and ample time.

343. The Tribunal noted that the allegations are serious. The doctor's case could be adversely affected if the tribunal were to proceed in the absence of a statement from him and the opportunity to challenge the evidence put before the tribunal. The tribunal applied the principles set out in Jones and considered that on the face of the information before the Tribunal he had ample opportunity to present his arguments adequately and participate effectively. The doctor's presence at the hearing was his right but not his obligation.

344. The Tribunal considered carefully whether the existence of a police investigation should lead to adjournment. The Tribunal noted that criminal and regulatory proceedings serve different purposes and require the application of different legal tests and standards. There is no firm rule of precedence requiring the Tribunal to await the outcome of a criminal investigation. On the material before it, The Tribunal considered that the criminal investigation appears dormant with no clear timescale. Indeterminate delay would not serve the overarching objective or the interests of the parties. Concerns raised regarding potential satellite issues arising from proceeding with regulatory proceedings first could be adequately managed by the criminal trial process. There was no risk of creating an abuse of process as the doctor could still receive a fair criminal trial. In the unexplained absence of the doctor, proceeding with the fitness to practise proceedings before the conclusion of the criminal investigation would be fair.

345. In the absence of further information the Tribunal determined that Dr Tsakov has voluntarily waived his right to attend the hearing. He has not requested an adjournment, and there is no information to suggest that a short adjournment will secure his attendance at a date in the future. The Tribunal determined that given the concerns in this case, there is strong public interest in the hearing proceeding expeditiously. Accordingly, the Tribunal determined that it was fair and appropriate to proceed in Dr Tsakov's absence in accordance with Rule 31 of the Rules.

346. Further delay would risk compounding and prolonging the impact of the allegation and the proceedings on the complainant, who is to be treated as a vulnerable witness, and

may adversely affect the quality of her evidence. The time elapsed since the date of the matter that is the subject of the allegation is already six and a half years. The public interest in timely, effective regulation, protecting patients, maintaining public confidence, and upholding proper standards strongly favours that the hearing progress. Balancing all factors arising from the cases of Jones, Adeogba,and Ramaswamy the Tribunal determined that it is fair and in the public interest to proceed in Dr Tsakov's absence.