PUBLIC RECORD

Dates: 27/11/2023 – 01/12/2023; 29/07/2024 – 14/08/2024; 28/10/2024 – 29/10/2024

Medical Practitioner's name:	Dr Aliaksandr CHUPIN
GMC reference number:	6069247
Primary medical qualification:	Vrach 1996 Grodno Medical Institute

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

Summary of outcome

Suspension, 2 months.

Tribunal:

Legally Qualified Chair	Mr Robin Ince
Lay Tribunal Member:	Dr Caroline Friendship
Medical Tribunal Member:	Mr Gurpreet Singh

Tribunal Clerk:	Ms Fiona Johnston (27/11/2023 – 1/12/2023) Mr John Poole (29/07/2024 – 09/08/2024) Ms Maria Khan (12/08/2024 – 13/08/2024) Mx Nate Caruso-Kelly (28/10/2024 – 29/10/2024)

Attendance and Representation:

Medical Practitioner:	Present, represented
Medical Practitioner's Representative:	Mr Oliver Williamson, Counsel, instructed by the MDU

GMC Representative:	Ms Laura Barbour, Counsel

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 - 09/08/2024

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

Background

2. Dr Chupin qualified as a doctor in 1996 in Belarus and relocated to the UK in 2002. He started training as General Practitioner in 2016 after having worked as a hospital doctor in NHS hospitals in the North West for several years. His GP training included one and a half years working in hospitals and two and a half years working in GP surgeries. Thereafter he began work as a salaried GP at the Dunstan Village Group Practice ('the Practice') in Liverpool, in September 2020.

3. The allegation that has led to Dr Chupin's hearing relates to telephone consultations he undertook with two patients; Patient A on 28 October 2020 and Patient B on 13 July 2021. In summary it is alleged that Dr Chupin's failings related variously to history taking, assessment, management, safety netting, record keeping, advice and prescribing. It is further alleged that Dr Chupin made entries in both patients' medical records which he knew to be untrue, and that his actions were dishonest.

4. Dr Chupin's consultation with Patient A on 28 October 2020 occurred around six weeks after he began working at the Practice. Concerns were raised with the Practice from Patient A's daughter, Ms D, who had spoken to Patient A after the consultation and reported that she was upset, felt like she was not listened to and that no one had helped.

5. Dr Chupin's consultation with Patient B on 13 July 2021 took place nine months after he had started working at the Practice.

6. The GMC conducted separate investigations in relation to each patient but there was a successful joinder application for both matters to be considered by the same tribunal.

The Outcome of Applications Made during the Facts Stage

7. The Tribunal granted an application made by Mr Williamson on behalf of Dr Chupin to adjourn the hearing in accordance with Rule 29(2) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'). The application was made on 27 November 2023 (Day 2 of the hearing) and was made on the basis that further information was required to ascertain whether Dr Chupin had XXX at the material time of the Allegation. The hearing was actually adjourned on 1 December 2023 (Day 5 of the hearing). The Tribunal's determination is attached at Annex A.

8. Mr Williamson had also made an application on Day 1 of the hearing pursuant to Rule 34(1) of the Rules to admit into evidence some scientific literature, consisting of four journal articles. However, following the adjournment of the hearing and further reports obtained, the application was withdrawn, and the literature was not considered by the Tribunal.

The Allegation and the Doctor's Response

9. The Allegation made against Dr Chupin is as follows:

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

<u>Patient A</u>

1. On 28 October 2020, you undertook a telephone consultation with Patient A and you:

   a. failed to take an adequate history in that you did not elicit information about:

i. a detailed history of pain; **Admitted and found proved**

ii. any associated 'red flag' symptoms; **Admitted and found proved**

iii. any bilateral pain; **Admitted and found proved**

iv. saddle numbness; **Admitted and found proved**

v. any associated sphincter disturbance causing bladder symptoms; **Admitted and found proved**

vi. any associated sphincter disturbance causing bowel symptoms; **Admitted and found proved**

b. failed to sufficiently explore significant symptoms; **Admitted and found proved**

c. unreasonably focussed upon one symptom; **Admitted and found proved**

d. failed to provide an adequate differential diagnosis for Patient A's condition; **Admitted and found proved**

e. failed to determine whether Patient A needed to be further assessed at a face-to-face appointment; **Admitted and found proved**

f. failed to consider the possibility that the back pain could be a result of malignancy; **Admitted and found proved**

g. failed to provide adequately detailed safety netting advice to Patient A; **Admitted and found proved**

h. failed to make an adequate record of the consultation in that you did not refer to the following reported symptoms:

i. breathlessness; **Admitted and found proved**

ii. weight loss; **Admitted and found proved**

iii. nausea (from taking Tramadol); **Admitted and found proved**

iv. fatigue. **Admitted and found proved**

2. In your record of the consultation, you noted that you had advised Patient A:

   a. 'on… manual handling'; **Admitted and found proved**

   b. 'on… rest'; **Admitted and found proved**

   c. 'to avoid heavy lifting'; **Admitted and found proved**

   d. 'to call us back if any red flags'. **Admitted and found proved**

3. You knew that during the consultation, you had not given any substantive advice on:

   a. manual handling; **To be determined**

   b. rest; **To be determined**

   c. avoiding heavy lifting; **To be determined**

   d. relevant red flag symptoms. **To be determined**

4. Your actions as set out at:

   a. paragraph 2a were dishonest by reason of paragraph 3a; **To be determined**

   b. paragraph 2b were dishonest by reason of paragraph 3b; **To be determined**

   c. paragraph 2c were dishonest by reason of paragraph 3c; **To be determined**

   d. paragraph 2d were dishonest by reason of paragraph 3d. **To be determined**

<u>Patient B</u>

5. On 13 July 2021, you undertook a telephone consultation with Patient B, and subsequently spoke to her partner, Mr C, and you:

a. failed to elicit an adequate history from Patient B's partner, Mr C, in that you failed to enquire about:

i. falls or trauma to the back; **Admitted and found proved**

ii. any radiation of pain into the legs; **Admitted and found proved**

iii. any neurological symptoms; **Admitted and found proved**

b. failed to adequately assess Patient B's presenting condition; **Admitted and found proved**

c. failed to arrange a face-to-face consultation with Patient B; **Admitted and found proved**

d. failed to provide an adequate differential diagnosis for Patient B's Admitted condition; **Admitted and found proved**

e. failed to formulate an adequate management plan; **Admitted and found proved**

f. failed to provide adequate safety-netting advice; **Admitted and found proved**

g. inappropriately prescribed:

i. Nefopam; **Admitted and found proved**

ii. Tramadol; **Admitted and found proved**

6. In your original record of the consultation with Patient B and Mr C ('the Original Record'), as reproduced at Schedule 1, you:

a. failed to record the involvement of Mr C in your assessment and/or management of Patient B; **Admitted and found proved**

b. noted that Patient B:

i. had not suffered "recent falls"; **Admitted and found proved**

ii. 'asked for stronger pain killers'; **Admitted and found proved**

iii. was 'happy with the [treatment] plan'. **Admitted and found proved**

7. You knew that during the consultation:

   a. you had not asked, or been told about, whether Patient B had suffered any recent falls; **To be determined**

   b. Patient B did not request painkillers; **To be determined**

   c. you had not spoken directly with Patient B about your proposed treatment plan; **To be determined**

   d. Mr C had expressed a view to you that Patient B should be admitted to hospital due to ongoing serious pain. **To be determined**

8. Your actions were dishonest as set out at:

   a. paragraph 6(b)(i) by reason of paragraph 7(a); **To be determined**

   b. paragraph 6(b)(ii) by reason of paragraph 7(b); **To be determined**

   c. paragraph 6(b)(iii) by reason of paragraph 7(c)-7(d). **To be determined**

9. Having learned of Patient B's death on 13 July 2021 you amended the Original Record and, in that amended record, as reproduced at Schedule 2, you:

   a. altered the read code entry of 'Low Back Pain' from an 'active' to a 'past' problem; **Admitted and found proved**

   b. added additional detail, which did not fully reflect the true content of the conversations you had with Patient B and Mr C; **To be determined**

   c. failed to record that you:

      i. had been made aware of Patient B's death at the time of your amendments; **Admitted and found proved**

      ii. were making a retrospective entry/amendment to the record. **Admitted and found proved**

10. When you altered the Original Record you knew that:

a. during the consultation neither Patient B nor Mr C had made reference to low back pain; **To be determined**

b. your record keeping of your consultation with Patient B and Mr C would be subject to scrutiny; **To be determined**

c. by virtue of you not noting that you had made a retrospective amendment to the record, the true content of the Original Record was potentially obscured. **To be determined**

11. Your actions as set out at paragraph 9 were dishonest by reason of paragraph 10. **To be determined**

The Admitted Facts

10. At the outset of these proceedings, through his counsel, Mr Williamson, Dr Chupin made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

The Facts to be Determined

11. In light of Dr Chupin's response to the Allegation made against him the Tribunal is required to determine the remaining paragraphs of the Allegation. In essence, the Tribunal must determine the paragraphs of the Allegation where it is alleged that Dr Chupin's actions were dishonest.

Witness Evidence

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

- Witness statement of Ms D, dated 6 July 2023
- Witness statement of Mr C, dated 7 July 2023
- Witness statement of Dr E, Clinical Investigator, dated 4 August 2024. Dr E carried out an investigation into Dr Chupin's treatment of Patient B and provided a report
- Witness statement of Ms F, Practice Manager at Dunstan Village Group Practice, dated 10 October 2023. She had initially dealt with the complaints relating to Patient A and Patient B.

13. Dr Chupin provided his own witness statement dated 23 October 2023 and gave oral evidence to the Tribunal.

14. In addition, the Tribunal received testimonial evidence in support of Dr Chupin, including from Dr G, General Practitioner at the Practice, who gave evidence to the Tribunal via videolink.

Expert Witness Evidence

15. The Tribunal also received evidence from two expert witnesses, Dr H, a General Practitioner, instructed on behalf of the GMC, and by Dr I, a Principal in General Practice, instructed on behalf of Dr Chupin. Both gave oral evidence to the Tribunal.

16. Dr H provided a report concerning Patient A, dated 22 December 2021, and a supplemental expert report concerning Patient A, dated 6 June 2023. He provided a report concerning Patient B, dated 22 July 2022, and a two supplemental expert reports concerning Patient B, dated 5 June 2023 and 4 August 2023.

17. Dr I provided a report dated 18 October 2023.

18. Dr H and Dr I produced a joint expert report, dated 18 October 31 October 2023, and provided supplemental reports on 1 & 2 August 2024.

XXX

19. XXX

20. XXX

21. XXX

22. XXX

23. XXX

Documentary Evidence

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

- Extracts of the relevant medical records pertaining to Patient A and Patient B
- Audio recording of telephone consultation with Patient A, 28 October 2020
- Audio recordings of telephone consultations with Patient B and Mr C, 13 July 2021
- Transcripts of audio recordings
- EMIS record relating to Patient B
- Redacted NHS England Investigation Report regarding Patient B, 23 June 2022
- Dr Chupin's Rule 7 response concerning Patient A, 9 March 2021; & further response on 18 August 2022
- Dr Chupin's Rule 7 response concerning Patient B, 11 November 2022
- Various testimonial letters in support of Dr Chupin, 2023

The Tribunal's Approach

25. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Chupin 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.

26. The Tribunal had regard to the detailed written submissions provided by parties, on which they also elaborated orally.

27. The LQC advised that Dr Chupin was of good character which meant that the Tribunal is entitled to take into account Dr Chupin's good character, firstly, on the basis that it support his credibility and therefore can be taken into account when decided whether to believe him; and secondly, on the basis that the Tribunal is entitled to conclude that, because of his good character, he is less likely than otherwise might have been the case to act as alleged. The LQC advised, however, that good character is not determinative.

28. The Tribunal took into account the case of *Re B (Children) (Care Proceedings: Standard of Proof) (CAFCASS intervening)* [2008] 3 WLR 1: [2009] 1 AC 11, which provided that:

> *'in general, the more serious the allegation (such as dishonesty) the more cogent will be the evidence for which a tribunal will be looking. In some cases it will need to look at the facts more critically or anxiously. However this does not require a different standard of proof. Essentially, in such circumstances, a tribunal needs to subject the evidence relied upon by the GMC to a critical, anxious and heightened scrutiny…'*

29. The Tribunal was also mindful of the case of *Byrne v GMC [2021] EWHC 2237* and the quote therefrom as to what constitutes "*heightened scrutiny*" namely:

> *"First, the seriousness of an allegation does not of itself require more cogent evidence…Rather it depends on the inherent probability of the relevant conduct…'*

30. In relation to the allegation of dishonesty, the LQC referred the Tribunal to the approach adopted in the case of *Ivey v Genting Casinos (UK) Limited t/a Crockfords [2017] UKSC 67,* in which it was summarised that:

> "*The fact-finding tribunal must ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts and then determine whether his conduct was honest or dishonest by the (objective) standards of ordinary decent people*."

The Tribunal's Analysis of the Evidence and Findings

31. 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.

Patient A

Paragraph 3 a – d

32. The Tribunal considered whether Dr Chupin knew, that during the consultation with Patient A, he had not given any substantive advice on manual handling, rest, avoiding heavy lifting, and relevant red flag symptoms.

33. The Tribunal noted that the audio recording of the consultation with Patient A and the transcript of the recording show that Dr Chupin did not advise on any of these matters. The telephone call commenced at 14:38:42 and lasted 3.36 minutes, therefore ended on or about 14:42:18.

34. The Tribunal bore in mind that Dr Chupin did not make the entry in Patient A's medical records at the time of the consultation but later, at 14:48:36, some 6.18 minutes after the telephone call ended. In his evidence he stated that his standard practice was to make an entry in the medical records following the consultation as he preferred not to 'talk and type'.

35. In his witness statement, Dr Chupin stated that:

'Following the consultation, and before I had a chance to make an entry in the notes, a receptionist called to ask me to reissue a prescription for another patient. I now know that I entered the records of that patient at 14.43 in order to do so. I returned to the record of Patient A at 14.48 and made my entry in the records…'

36. Dr Chupin further stated that:

'I see patients presenting with back pain every day and I usually (as part of my standard practice) advise them to avoid manual handling, to rest, to avoid heavy lifting and to contact the surgery again if they develop any red flag symptoms. This is part of my 'standard advice' to patients presenting with mechanical back pain. I recognise that I did not give that advice in this case, and I did not treat Patient A in accordance with the standards which I should have and apologise unreservedly for my failings.

I strongly deny being dishonest. When making my entry in the records, I must have assumed that I had given Patient A advice in line with my standard advice, otherwise I would not have recorded having done so. When I made the entry in the records I was not acting dishonestly in any way.

At the time of making the note I did not [realise] that I had not given the advice and if I had realised, I would never have recorded that I did. I believe what is likely to have happened when making my entry in the records, owing to [XXX] I was suffering, I was acting on 'autopilot'. As a result, I recorded that I had advised as recorded, believing that I had done so, and not because I was being dishonest or ever intending to mislead anyone. I was aware that all telephone consultations were recorded…'

37. The Tribunal took account of Ms Barbour's submissions regarding Patient A. She suggested that Dr Chupin (who had not treated Patient A before) rushed the consultation (spending just under four minutes on the call notwithstanding that ten minutes was allocated). Dr Chupin had cut corners by diagnosing Patient A's stomach pain as referred pain from her back, thereby assessing Patient A as someone with a relatively low level problem (albeit consistent with previous treatment to her back). Ms Barbour maintained that, as Dr Chupin had not given any of the usual advice GPs gave in relation to back pain, he decided to

make an inaccurate record of his consultation to make it appear that he had given appropriate advice, when he had not, in order to make it apparent to his colleagues that he had done a proper job.

38. The Tribunal accepted Mr Williamson's submission that the word 'know' means 'to be or feel certain of the truth or accuracy of a fact'.

39. The Tribunal reminds itself of the note made of his consultation with Patient A by Dr Chupin, as set out in paragraph 2 of the expert report of Dr H:

> '…Dr Chupin undertook a telephone consultation with Patient A Dr Chupin's medical record stated that a history was taken of:
>
> > *Long term history of back pain radiating to lower limbs, chest abdomen, multiple allergies to analgesia.*
>
> Dr Chupin recorded a diagnosis of 'Backache' using a Read code. Dr Chupin recorded his management plan as:
>
> > *Advised on analgesia, manual handling, rest, to avoid heavy lifting, to call us back if any of the red flags.*
> > *Advised to call us back if no improvement. Patient is happy with the plan.*
>
> Dr Chupin prescribed Nefopam 30mg tablets one three times daily x 30 and Diclofenac Gel 1.16% [apply topically] twice a day to the lower back x 100g tube.
>
> The **audio recording** of the telephone consultation can be summarised thus:
>
> > Dr Chupin introduced himself and confirms he was talking to Patient A… gave a history of ongoing stomach pain, breathing problems, a sore tongue, fatigue and weight loss.
> > (up to 0.48 mins)
> >
> > Dr Chupin reviewed Patient A records, and then said that because he only had 10 minutes for the appointment Patient A would need to prioritise her problems. Patient A stated that she is most concerned about her stomach and her breathing. (1.37 mins)

> Dr Chupin then said: 'Stomach or breathing?' and Patient A elected to tell him about her stomach. She said she was in severe pain, feeling like her stomach was being crushed, that it was worse on sitting or standing, was affecting her ability to eat and was right sided, from under the right breast down to the hip. (2.03 mins)
>
> Dr Chupin then said: 'The actual problem is not in your stomach, but it is in your lower back… it is referred pain.' Dr Chupin said he wanted to give Patient A pain killers and cream to be applied to her back and not her stomach. (3.00 mins)
>
> Dr Chupin clarified what side effects that Patient A stated she had experienced from Codeine and said he would prescribe her 'something else.' Dr Chupin's safety netting and follow up advice was: 'let's see what is going to happen… give us a call after about four weeks if there is no help.' (3.36 mins)'

40. The Tribunal considered that it was plausible that, at the time that Dr Chupin made the entry in Patient A's medical notes, he could not recall exactly what he had said during the consultation and recorded what he thought he would have advised as per his standard practice.

41. The Tribunal accepted that Dr Chupin would see patients presenting with back pain every day and that his usual practice was to advise them to avoid manual handling, to rest and to avoid heavy lifting. Dr G, a fellow GP from the Practice, also confirmed in her evidence that the Practice would see patients presenting with back pain every day.

42. The Tribunal also heard from both experts that for doctors dealing with patients with back pain, it was 'routine' to give advice regarding manual handling, rest, and avoiding heavy lifting. They described these three things as generic advice coming as a package. The experts also considered that it was only necessary to have recorded advice relevant to red flag symptoms.

43. The Tribunal considered that it was not improbable that, when making the entry in Patient A's medical record, Dr Chupin would have focussed on the back pain and wrote the usual advice he would give. The Tribunal considered that it was plausible that, due: to the delay in writing up the notes; Dr Chupin having to re-issue a prescription for another patient

in that period; as well as the other factors regarding Dr Chupin's lack of focus at the time arising from XXX, Dr Chupin might not have recalled specifically what advice he had given. Both experts agreed that an interruption – such as reissuing a prescription for another patient, which involved looking at their patient record, – might be significant in Dr Chupin making an inaccurate record. The Tribunal considered that it was not unreasonable for him to assume he had given the advice based on his usual practice.

44. Furthermore, the experts advised that when a GP undertakes any consultation, there is a risk of 'confirmation bias' as the GP usually has in mind where they are going with the consultation, and the writing of the note is often informed by the end point reached.

45. The Tribunal also accepted the evidence that Dr Chupin suffered from XXX at the material time and this is likely to have affected his performance at work, particularly in relation to his concentration. It also noted that this was a particularly stressful period for GPs working at the time of the COVID-19 pandemic and he was only seven weeks into his contract at the Practice. The Tribunal further noted the evidence that Dr Chupin had XXX in 2019 XXX.

46. The Tribunal therefore considered it plausible that Dr Chupin could not recall what advice he had given and made an assumption based on his usual practice. As such, it follows that he did not 'feel certain of the truth or of the accuracy of a fact' and therefore did not 'know' what he had advised at the time that he made the entry into Patient A's records. The Tribunal was also mindful of Dr Chupin's good character and the inherent probability of him deliberately recording something he knew not to be correct.

47. The Tribunal determined that it has not been established by the GMC, on the balance of probabilities that Dr Chupin knew that he had not given any substantive advice on manual handling, rest, avoiding heavy lifting, and relevant red flag symptoms. At most, the Tribunal considers that the evidence in relation to this charge is finely balanced.

48. The Tribunal therefore found paragraphs 3a-d of the Allegation not proved.

Paragraph 4 a – d

49. Given the Tribunal's findings in relation to paragraph 3 of the Allegation, paragraph 4 falls away. Accordingly, the Tribunal found paragraph 4 a -d not proved.

50. The Tribunal pauses there to comment, that even if it had found paragraph 3 a -d proved, it would not necessarily follow that Dr Chupin's motivation was dishonest, as Dr Chupin also recorded giving advice which he was not required to record (namely 'the generic advice' regarding manual handling, rest, and the avoidance of heavy lifting), which the Tribunal considered to be inconsistent with a dishonest motivation.

Patient B

Paragraph 7 a – d

51. By way of background to the consultation pertaining to Patient B, Dr Chupin outlined in his witness statement that, on 13 July 2021, he had been working at the Practice for nine months and was still finding the job stressful and having difficulty XXX. He also explained that, on the day, he was the doctor-on-call, and therefore in addition to holding a morning surgery between 9.00am and 12.00pm, and an afternoon surgery between 2.40pm and 5.40pm, he also had responsibility for dealing with emergency telephone calls, urgent queries, and urgent prescriptions. He detailed that he had a total of 27 appointment slots, 3 triage calls and 3 home visits.

52. The Tribunal reminds itself of the initial note made by Dr Chupin as set out in Schedule 1:

Schedule 1

History	still drinking alcohol daily, vomiting, no sob, no chest pain, no recent falls, asked for stronger painkillers,
Comment	agreed to tramadol nefopam advised to call us back if no improvement patient is happy with the plan

53. The Tribunal noted that, unlike the case of Patient A where Dr Chupin made an entry in the records a short while after the consultation, having dealt with a prescription for another patient in the intervening period, in Patient B's case Dr Chupin made his first entry in the record almost immediately after the consultation. The Tribunal therefore considered that, in contrast to Patient A's consultation, there likely was a greater probability that Dr Chupin would better recall the details of Patient B's consultation when making a record of that consultation. Further, the Tribunal noted that there was more than one telephone

consultation. Dr Chupin spoke to Patient B at 12:35:46 for 1.06 minutes. He then spoke to Mr C, Patient B's partner, from 12:37:26. This call lasted 5.25 minutes and therefore ended at about 12:43. Dr Chupin then made his entry into Patient B's medical records at 12:47.

54. The Tribunal notes that Dr Chupin was interviewed by Dr E on 9 June 2022 during the NHSE investigation into Patient B's case. During his interview Dr Chupin stated:

> *'Dr Chupin explains that his normal practice is to look at the patients record prior to calling a patient, he noted the patient's history including that she had a history of back pain and was on regular pain killers.*
>
> *Dr Chupin explained how he found it difficult to get any history from the patient and her speech was slurred, however noted that she did not appear to be breathless or distressed with pain during the telephone call.*
>
> *Dr Chupin called back and spoke to her partner as he wanted to get a clearer history, he initially agreed with the partners thoughts about wanting hospital admission but then wanted to explore the problem in more detail as he didn't think the patient sounded distressed on the phone.'*

55. Further, with regard to the coding of the problem, as 'back pain', Dr E stated:

> *'a) Problem coding The problem was coded as low back pain however there is no specific mention of back pain in the telephone call to the patient or her partner. Dr Chupin cannot recall why he coded back pain; we noted the telephone call to the partner mentioned left sided pain, but the site was not specified despite Dr Chupin trying to clarify this. Dr Chupin thinks he may have assumed it was back pain based on the patient's past history of back pain and regular medication of co-codamol.'*

56. In addition, the report also records:

> *'I asked Dr Chupin about the decision to prescribe and the choice of medication… He was prescribing for a musculoskeletal / back pain problem. On reflection he feels he should have arranged to assess the patient face to face with a home visit if needed. Dr Chupin has, on review of our draft interview notes clarified this to explain his first option would be to call an ambulance for the patient as home visiting would not be fast enough, he explained this is in his reflective statement but he was not able to*

> *make this clear during our meeting. His reflective statement does outline this and includes the following sentence 'In hindsight I should have booked an ambulance. If I was too busy to respond immediately, I should have asked my colleagues to help call Patient B'*

57. Moreover, the Tribunal noted Dr Chupin's oral evidence in re-examination. He was asked by Mr Williamson to comment upon Dr Chupin telling Mr C, during the telephone call, that 'I can refer her, it's not a problem' (which referred to him ordering an ambulance for Patient B). Dr Chupin replied 'I wanted to explore symptoms. When we refer to hospital we cannot just refer – I needed a reason otherwise it would be a major problem because it would be a waste of resources. I did not think I had enough. I thought his tone of voice changed and that he agreed.'

58. Mr Williamson then asked Dr Chupin whether he believed that he had refused to send Patient B to hospital, to which Dr Chupin replied 'No'.

59. Moreover, the Tribunal also notes that, during cross-examination, Dr Chupin agreed that his conversation with Mr C about the options of calling an ambulance or giving Patient B stronger painkillers was a 'negotiation'. The Tribunal also takes account of the risk of confirmation bias as referred to in paragraph 44 above.

60. Taking all these factors into account, the Tribunal considered that it was possible that, having reached what he considered was an agreement with Mr C, to try painkillers before sending Patient B to hospital, Dr Chupin may well have focussed on the outcome of the consultation rather than on the specific details.

<u>Paragraph 7a</u>

61. The Tribunal considered whether Dr Chupin 'knew' that, during his consultation with Patient B, he had not asked or been told about whether Patient B had suffered any recent falls.

62. The Tribunal listened to the audio recordings regarding Patient B and had regard to the transcript of the recordings. It agrees that there was no discussion regarding 'recent falls'.

63. In his evidence, Dr Chupin accepted that he recorded that Patient B had not suffered recent falls when he had not been told or asked about recent falls. He stated:

'...I have listened back to the call and I readily accept that the record I made was not accurate in the respects identified. It is no excuse but, by way of explanation, I believe I will have made the entry in a rush. When someone complains of pain, my usual practice is to ask whether they have suffered a recent fall, especially patients who are elderly and/or consume a lot of alcohol as they can fall/sustain a fracture more easily. When making my entry in the records, I was not made aware there had been any fall and must have had it in my mind that I asked a question about falls. I now recognise that did not occur and I apologise unreservedly. At the time I wrote it I genuinely did not know that what I was writing was incorrect...'

64. The Tribunal first of all notes that, although falls were not mentioned during the consultation, it was correct that Patient B had not suffered any recent falls, so to that extent, the note was accurate, albeit inadvertently. Moreover, as indicated above the Tribunal considered that it was possible that, as Dr Chupin had reached agreement with Mr C following a 'negotiation', his mind was concentrated on that outcome and not on the details of the conversation.

65. Taking all these matters into account, the Tribunal accepted Dr Chupin's evidence on this specific point and concluded that it was more likely than not that he assumed that he had asked a question about falls. It considered it less probable that he made an entry regarding falls knowing that he had not discussed this. The Tribunal saw no reason to doubt that it was his usual practice to ask about recent falls, especially in the context where a doctor was considering whether it was necessary to refer a patient to hospital and whilst no falls were discussed, it is more probable that when making an entry in the original that this was an oversight.

66. Although Dr Chupin made his note about the consultation very soon after the consultation with Mr C, as a significant part of their discussion was on other topics, the Tribunal considers that it is plausible that Dr Chupin may well have forgotten about the other details of their conversation. Moreover, the Tribunal notes that Dr Chupin was still having problems with XXX at this time and therefore it is plausible that this continued to affect his concentration. Moreover, the Tribunal notes that both experts agreed that, listening to the call, Dr Chupin 'does not sound entirely [XXX] whilst consulting' and that 'a doctor who was [XXX] and was working [XXX], might have trouble recalling accurately the contents of a telephone consultation.' The Tribunal therefore determined that the evidence in relation to this charge is finely balanced and that it has not been established by the GMC, on the balance

of probabilities that Dr Chupin knew that he had not been asked, or been told about, whether Patient B had suffered any recent falls.

67. Accordingly, the Tribunal found paragraph 7a not proved.

Paragraph 7b

68. The Tribunal considered whether Dr Chupin knew during his consultation with Patient B, that Patient B did not request painkillers.

69. In his evidence, Dr Chupin accepted that he recorded 'asked for stronger painkillers' and that Patient B/Mr C did not request painkillers. He stated that:

> '*I obviously made a mistake but when making my entry in the notes I must have been thinking that 'asked for stronger painkillers' reflected the outcome of the discussion we had. I accept that Patient B/Mr C did not ask me for painkillers but doing the best I can to understand what happened, I think at the time it might have been my interpretation that because it was reported that Patient B takes painkillers but they don't take away the pain, it was appropriate to prescribe different or better painkillers. Whilst Mr C had asked for a referral to hospital, at the end of the call he had indicated that he would collect Patient B's painkillers that day…'*

70. The Tribunal notes from the transcript of the consultation that Mr C, on or about five occasions, specifically rejected the suggestion that Patient B needed additional or better painkillers, before eventually agreeing to that cause of action. Taking into account the fact that the telephone call had ended some four minutes earlier, the Tribunal therefore has difficulty accepting that Dr Chupin had completely forgotten this aspect of the consultation when making his record. Consequently, the Tribunal determined that the GMC has established, on balance, that at the time he made the record, Dr Chupin 'knew' that, during the consultation, Patient B did not request painkillers.

71. Accordingly, the Tribunal found paragraph 7b proved.

Paragraph 7c

72. The Tribunal considered whether Dr Chupin knew that during his consultation with Patient B, he had not spoken directly with her about her proposed treatment.

73. Dr Chupin accepted that he recorded 'patient is happy with the plan' and that he had not spoken directly to Patient B about the plan. In his witness statement, he stated that:

> *'I had spoken to both patient B and Mr C and I think in my mind, when writing the note up quickly they in effect became one person. It is my usual practice to record 'patient happy with plan' or similar when a plan is advised and the patient agrees. It is not uncommon to communicate with next of kin on behalf of a patient. I accept I should have recorded more details about the discussion with Mr C and that I had not spoken directly to Patient B about the plan…'*

74. The Tribunal considers that Dr Chupin more or less accepted that he had known, when making the record of the consultation, that he had not spoken directly with Patient B about the proposed treatment plan. In any event, the Tribunal would have found this charge proved on the basis that Dr Chupin had spoken with Mr C for over five minutes and likely would not have forgotten this when making the record some four minutes later.

75. Consequently, the Tribunal determined that the GMC has established, on balance, that at the time he made the record, Dr Chupin 'knew' that, during the consultation, he had not spoken directly to Patient B about the proposed treatment plan.

76. Accordingly, the Tribunal found paragraph 7c proved.

Paragraph 7d

77. The Tribunal considered whether Dr Chupin knew that, during his consultation with Patient B, Mr C had expressed a view to him that Patient B should be admitted to hospital due to ongoing serious pain.

78. The Tribunal listened to the audio recording and had regard to the transcript, noting that on at least four occasions Mr C expressed a view that Patient B should go to the hospital and that, on at least one occasion, Dr Chupin said that he could refer her.

79. Dr Chupin accepted that he had a conversation with Mr C about hospital but that following the conversation about painkillers, Mr C agreed to pick up painkillers later that day. In his witness statement Dr Chupin stated that:

'…Having reviewed Patient [B']s medical history, I noted a history of back pain and I think I must have wrongly assumed that this was the pain being complained of. I acted in good faith, believing that stronger painkillers would alleviate Patient B's problem…'

80. The Tribunal has applied the same reasoning to this paragraph of the Allegation as it did in relation to paragraph 7b. Consequently, the Tribunal determined that the GMC has established, on balance, that at the time he made the record, Dr Chupin 'knew' that, during the consultation, Mr C had expressed a view that Patient B should be admitted to hospital due to ongoing serious pain.

81. The Tribunal therefore found paragraph 7 d proved.

Paragraph 8a – c

Paragraph 8a

82. Given that the Tribunal found paragraph 7a of Allegation not proved, paragraph 8a falls away.

Paragraph 8b

83. The Tribunal considered whether Dr Chupin's actions, by noting in the original record of the consultation with Patient B and Mr C that Patient B 'asked for stronger painkillers', was dishonest by reason of him knowing that she had not asked for stronger pain killers.

84. Whilst the Tribunal considered that Dr Chupin's entry in the original record was not fully representative of the consultation, the Tribunal bore in mind that there was a discussion and negotiation with Mr C regarding prescribing stronger painkillers, which concluded with Mr C agreeing to go and collect stronger painkillers from the pharmacy. The Tribunal considered that it was not uncommon to communicate with a next of kin on behalf of a patient and that there was agreement by Mr C to the proposed course of action of prescribing stronger pain killers and waiting two more days.

85. Accordingly, whilst it is correct that Patient B did not ask for stronger painkillers, the Tribunal has found that her next of kin ultimately agreed to following that course and, indeed, went to the pharmacy to collect them, which emphasises the fact that a consensus had been reached. Consequently, the Tribunal considers that, notwithstanding that the entry was inaccurate and misleading, Dr Chupin has provided a plausible innocent explanation for his actions and that ordinary decent people would not consider them to be dishonest. It

therefore follows that the GMC has not established, on the balance of probabilities, that Dr Chupin had been dishonest in recording that Patient B had asked for stronger painkillers when he knew that she had not.

86. The Tribunal therefore found paragraph 8b not proved.

Paragraph 8c

87. The Tribunal notes that paragraph 8c refers to Dr Chupin's actions in paragraph 6biii being dishonest due to his actions in both paragraphs 7c and 7d. The Tribunal has therefore considered these matters together.

88. The Tribunal therefore considered whether Dr Chupin's actions, in noting in the original record of the consultation with Patient B and Mr C, that Patient B was happy with the treatment plan, was dishonest by reason of (i) him knowing that he had not spoken directly with Patient B about his proposed treatment plan and (ii) him knowing that Mr C expressed a view that Patient B should be admitted to hospital due to ongoing serious pain.

89. The Tribunal repeats its reasoning in paragraph 84 above. Further, the Tribunal reminds itself that, during the consultation with Mr C, Dr Chupin had made enquiries of Mr C to ascertain whether it was necessary to send Patient B to hospital by asking whether she: had been vomiting; had diarrhoea; or had any shortness of breath, before forming the plan to prescribe stronger painkillers, to which Mr C agreed.

90. The Tribunal considered Dr Chupin's explanation plausible that, when he wrote up the record he was doing it quickly and Patient B and Mr C *'became one person'*. It also accepted that it was his usual practice to record *'patient happy with plan'* or words to that effect when a plan is advised and the patient agrees – it noted from other consultation records that this phrase had been used by Dr Chupin. The Tribunal considers that, notwithstanding that the entry was inaccurate and misleading, Dr Chupin has provided a plausible innocent explanation for his actions and that ordinary decent people would not consider them to be dishonest. It therefore follows that the GMC has failed to prove, on the balance of probabilities, that his actions in this regard were dishonest.

91. The Tribunal therefore found paragraph 8c not proved.

Paragraph 9b

92. The Tribunal considered whether, having learned of Patient B's death on 13 July 2021, Dr Chupin amended the Original record, by adding additional detail which did not fully reflect the true content of the conversations he had with Patient B and Mr C.

93. The Tribunal notes that Dr Chupin felt that he could not admit this charge since he was unsure what 'additional detail' was alleged to have been added. The Tribunal has noted the written submissions on this point by both Ms Barbour and Mr Williamson (who added an addendum to his initial submissions when asked by the Tribunal whether the parties had anything further on the point).

94. The Tribunal considers that the answer lies in the stem of paragraph 9 of the Allegation, which states 'having learned of Patient B's death on 13 July 2021 you amended the Original Record… <u>as reproduced at Schedule 2</u>…' (the Tribunal's emphasis). Schedule 2 states:

History	still drinking alcohol daily, **slurred speech on the phone, no** vomiting, no sob, no chest pain, no recent falls, asked for stronger painkillers **due to ongoing pain, passed the phone to her son, who informed that the patient is in pain, and current painkillers are not helping, informed about the recent blood results, agreed to try tramadol for 1 – 2 days, if no response to call back**
Comment	agreed to tramadol nefopam advised to call us back if no improvement patient is happy with the plan

95. Consequently, the Tribunal considers that, on a normal reading of paragraph 9b, the 'additional detail' is as set out in Schedule 2.

96. In his witness statement, Dr Chupin stated that when he found out that Patient B had died, he was shocked and extremely upset as he had never previously been in a situation in which a patient had died a couple hours after his consultation. He stated that:

'I was shocked and I think I will have gone back into the record to see what took place. I think when I did so it would have been apparent that I had made my entry in a rush

and that details which I still recalled were missing. I added some missing detail, and it is my understanding that I did so at 15.24. I knew that others would likely review the recently deceased patient's records and I wanted to make my entry more detailed and easier to understand. At the time I was shocked that a patient had recently died. It did not occur to me that I could be criticised for my management.

97. The Tribunal also notes that most of the additional detail that Dr Chupin added was accurate, for example the addition of 'no' before vomiting. The Tribunal agrees (as did the experts) that Patient B's speech was slurred at times. Further, it is correct that Mr C confirmed that Patient B was experiencing 'ongoing pain' and that he informed Dr Chupin of this and also that Patient B's current painkillers were not effective. (The Tribunal pauses there to comment that Mr C said that Patient B was 'screaming' in pain but that was not apparent from the recording of Dr Chupin's conversation with Patient B). It is correct that Dr Chupin informed Mr C about the 'recent blood results' and that Mr C 'agreed' to try Tramadol for 1 - 2 days and to call back if Patient B had not responded.

98. However, the Tribunal observed the Dr Chupin recorded that Patient B had 'passed the phone to son' which was incorrect and did not reflect what had transpired. Patient B had seemingly hung up the phone, and Dr Chupin spoke to her partner Mr C two minutes after, and Mr C had made it clear that he was Patient B's partner. However, the Tribunal considers that nothing significant turns on this, since Mr C was the next of kin and agreed to the course of treatment proposed.

99. Dr Chupin has not denied that he added the 'additional detail' as 'reproduced at Schedule 2'. The question for the Tribunal is whether the additional detail did not fully reflect the true content of the conversation Dr Chupin had with Patient B and Mr C.

100. The Tribunal notes Mr Williamson's addendum submissions on the point paragraph 9, which states:

'9. The GP experts added [200-201]:
"The experts agreed that additional detail was added to Dr Chupin's record and that this first element of the allegation was factually correct. However, the experts jointly reviewed the record made by Dr Chupin and the transcript of the telephone consultations in detail and concluded that ***while the additional information added by Dr Chupin did not fully reflect the content of the conversations****, he had with Patient B and Mr C,* ***the disparity was within the bounds of what might reasonably be expected***

> ***of a general practitioner making a retrospective entry in a medical record****. The experts agreed that overall, the changes made by Dr Chupin represented a more accurate record of what had occurred than his original record, the limited nature of which they were both critical of. On balance the experts agreed that* ***in terms of the additional detail that was added Dr Chupin's record keeping was at the standard expected****."…*

101. The Tribunal takes account of the expert opinion that the additional information did not fully reflect the content of the consultations. The Tribunal also notes that it is clear from the amendments that no reference is made to the 'negotiations' between Dr Chupin and Mr C or that Mr C was initially asking for Patient B to be taken to hospital. Notwithstanding the expert evidence (that the additional detail added was at the standard expected) as a matter of strict fact, the Tribunal concludes that the additional detail did not fully reflect the true content of the conversation with Patient B and Mr C.

102. The Tribunal therefore found paragraph 9b proved.

Paragraph 10

103. The Tribunal considers it might be helpful if it sets out the relevant timings relating to Patient B. The conversation with Mr C ended at around 12:43; Dr Chupin made the first entry into the records at 12:47; he was told of Patient B's death at 15:08 (2 hours 21 minutes later); in that period he was the duty doctor and was also carrying out consultations with a number of patients; Dr Chupin initially looked at Patient B's record at 15:19; he opened the records again at 15:27, when he made the amendments set out in Schedule 2; finally, at 16:09, Dr Chupin made the following entry 'paramedics contact, informed that patient passed away, while her partner went to pharmacy, staff informed, rest in peace'.

Paragraph 10a

104. The Tribunal considered whether Dr Chupin knew, when he altered the original record, that during the consultation neither Patient B nor Mr C had made reference to low back pain.

105. The Tribunal notes from the audit trail of the consultation that at 12:48 Dr Chupin entered 'Low Back Pain' as an observation and as a problem. In cross-examination Dr Chupin stated that he thought that, as Mr C said Patient B was in pain, 'on the side, just on the side you know' Patient B was suffering from back pain.

106. In his witness statement, Dr Chupin stated that he did not know why he entered back pain initially, or, when he went back into the record, why he changed back pain from an 'active' to a 'past' problem. The Tribunal has taken into account that Dr Chupin was informed of the death of Patient B about 2 hours 20 minutes after he completed the first entry into her records and that in the intervening period he had dealt with a number of other patients. Dr Chupin initially looked at Patient B's records at 15:19. The Tribunal notes, in passing, that those records do refer to her having received treatment for back pain in the past. Dr Chupin then closed Patient B's records but then revisited them at 15:27 when he made the amendments as set out in Schedule 2. Those amendments therefore were made some 2 and three-quarter hours after the end of the consultation with Mr C. Accordingly, the Tribunal concludes that it is plausible that Dr Chupin had forgotten specific details of the consultation (notwithstanding that most of his amendments were consistent with what had occurred during the consultation) due to the lapse of time and to the number of times in the interim that he was required to consider other patient records.

107. The Tribunal therefore considered that it was plausible that Dr Chupin made an assumption that Patient B had low back pain, an impression he said he gleaned from looking at her previous history and medication. The Tribunal once again notes Dr E's evidence on this point as set out in paragraph 55 above. The Tribunal was therefore not satisfied on the balance of probabilities Dr Chupin 'knew', when he altered the original record, that there had been no reference from either Patient B or Mr C regarding low back pain. The Tribunal considers that it was plausible that, given Patient B was described as being in pain by Mr C, and that Dr Chupin prescribed stronger painkillers, he incorrectly assumed there was back pain.

108. The Tribunal therefore found paragraph 10a not proved.

Paragraph 10b

109. The Tribunal considered whether Dr Chupin knew, when he altered the original record, that his record keeping of his consultation with Patient B and Mr C would be subject to scrutiny.

110. The Tribunal noted that in oral evidence Dr Chupin accepted that the reason why he changed the record was because he wanted it to be more accurate as he knew others would be looking at it. Further, in his witness stated he expressed:

> *'When I added details to the record, I had no intention of misleading anyone that might come to read it. I just wanted to add some details. I did not think the added information*

> *significantly changed the overall details and it was not my intention to do so, only to clarify what I had written before…'*

111. The Tribunal was satisfied therefore that Dr Chupin knew his record keeping would be subject to scrutiny given Patient B had died only a couple hours after his consultation.

112. The Tribunal therefore found paragraph 10b proved.

Paragraph 10c

113. The Tribunal considered whether Dr Chupin knew, when he altered the original record, that not noting that he had made a retrospective amendment to the record, the true content of the Original Record was potentially obscured.

114. In Dr Chupin's evidence he stated that:

> *'I fully accept that I should have made a separate entry and made it clear that I was adding detail retrospectively, and why and that I was doing so after I had been informed of Patient B's sad death. Whilst it is no excuse at all, it just did not occur to me at the time. I accept by my failure to do so the content of the original record was potentially obscured and I apologise unreservedly…'*

115. The Tribunal considered that it is a fundamental tenet of medical practice that a doctor must make it clear when an entry in the medical record is made retrospectively, especially in instances where there has been a watershed moment such as a patient's death or a complaint. All medical practitioners, including doctors, are told, right from the beginning of their training that retrospective entries must be separately recorded, or marked as amended retrospectively and this injunction would have been emphasised throughout their subsequent practices after qualification. Dr Chupin had been practising as a doctor since 1996 in Belarus and, after he came to the UK in 2002, practised specifically as a GP from 2016, a period of at least six years prior to the incident with Patient B. Accordingly, the Tribunal considers that such knowledge would have been ingrained into his practice. Furthermore, in answer to a question from the lay tribunal member, Dr Chupin confirmed that if an entry is not shown as retrospective, it 'could be interpreted as misleading'.

116. The Tribunal accepts that Dr Chupin was shocked by the death of Patient B, especially as he had spoken to her less than three hours earlier. It accepts that this might temporarily have affected his ability to concentrate. However, the Tribunal does not consider that this news would have caused Dr Chupin to completely forget such a fundamental tenet of

medical practice to the extent that he did not 'know' that, by not indicating that the entry was retrospective, the true content of that record was potentially obscured.

117. Consequently, notwithstanding the shock of Patient B's death, the Tribunal considered that Dr Chupin would still have known this, albeit it may not have been at the forefront of his mind at the time.

118. Accordingly, the Tribunal considered on the balance of probabilities that Dr Chupin knew that when he made the retrospective amendment it had the potential to obscure the true content of the Original Record.

119. The Tribunal therefore found paragraph 10c proved.

Paragraph 11

120. The Tribunal considered whether Dr Chupin's actions as set out at paragraph 9 of the Allegation were dishonest by reason of paragraphs 10b and 10c of the Allegation. In doing so it has reminded itself of Dr Chupin's good character.

121. After retiring to makes its decision on the Facts, the Tribunal asked for clarification from the parties as to how it was to apply paragraph 11 to paragraphs 9 and 10 of the Allegation. Ms Barbour responded as follows:

> *'Thank you for your e-mail, inviting our response to the question: 'is the Tribunal to consider whether 9a is dishonest only with reference to 10a and 9b only be reference to 10b and so on?'*
>
> *I have had the opportunity of speaking to Mr Williamson. I have sent him a copy of this e-mail and he has no submissions to add.*
>
> *The drafting of allegation 11 requires the Tribunal to consider, in turn, whether*
>
> - *the action set out at allegation 9(a) was dishonest by reason of all or any of the factors as set out at allegation 10 (a) – (c)*
> - *the action set out at allegation 9(b) was dishonest by reason of all or any of the factors as set out at allegation 10 (a) – (c)*
> - *the action set out at allegation 9(c)(i) was dishonest by reason of all or any of the factors as set out at allegation 10 (a) – (c)*

- *the action set out at allegation 9(c)(ii) was dishonest by reason of all or any of the factors as set out at allegation 10 (a) – (c)..'*

122. Furthermore, as the Tribunal had found paragraph 10a not proved, it took account of the fact it was only dealing with paragraphs 10b and 10c.

123. The Tribunal considered that the best approach would be to first consider whether there was anything inherently dishonest about Dr Chupin's actions as specified in paragraphs 9a, 9b and 9c and then consider whether Dr Chupin had been specifically dishonest under paragraphs 10b and 10c.

124. The Tribunal first considered whether Dr Chupin's action in altering the read code entry of 'Low Back Pain' from an 'active' to a 'past' problem was dishonest by reason of him (i) knowing that his record keeping would be subject to scrutiny and (ii) by virtue of him not noting that he had made a retrospective amendment to the Original Record.

125. The Tribunal first considered whether Dr Chupin's actions in changing the read code were inherently dishonest.

126. In Dr Chupin's evidence he stated:

'I do not know why I entered back pain initially or, when I went back into the record, why I changed it from 'active' to a 'past' problem. I do not think at the time I knew how to alter a read code. It is not something I have ever consciously done. I have since asked my practice manager how to do this and she showed me.

Whilst I cannot be sure, doing my best to understand what happened, I believe at the time I must have done so by mistake. The read code is very close to the diagnosis position on EMIS, possibly I accidentally clicked on it. To the best of my recollection, it would be 2 clicks to alter it: 1 click to open the table and a second click to change the read code..'

127. The Tribunal had regard to the supplemental expert reports provided by Dr I and Dr H on 1 and 2 August 2024 in which they were asked whether the Read code could be changed to 'past' by accident or mistake, and would the fact that a read code had been changed be apparent to the user?

128. The experts agreed that:

> *'Changing 'active' to 'past' requires two clicks. The first click brings up three options and the second click selects the option. In that sense the clicks have to be deliberate. Expressing no opinion on what happened in Dr Chupin's case, this could happen if for example the user doesn't know what they are doing and are clicking on several things to try to find something.*

And

> *'If you are changing 'active' to 'past' at the time of making the original entry, the system alerts you and asks you to enter the date for the past problem. When you return to the entry to amend it, and change 'active' to 'past', there is no alert. Once changed the word "active" just below the main problem says "past/ended" instead of "active". However, it is not something which is very obvious and quite easy to miss.'*

129. Further, the Tribunal notes Mr Williamson's submissions in paragraph 194:

> *'Indeed, the GP experts have not come up with any reason why Dr Chupin would conceivably have deliberately edited the read code [200]:*
> *"The experts also agreed that … this would not be such as to obscure Dr Chupin's record nor make it appear to not have been the final consultation that occurred with Patient B before her death, nor could the experts see how it would confer any benefit on Dr Chupin to do so".*

130. Taking all these factors into account, namely that: Dr Chupin could not remember why or how he had changed the read code; the experts agreed that it could be done by accident; the experts also agreed that such an amendment would not obscure the fact that his was the final consultation with Patient B before her death; and also that they agreed that they could not see how changing the read code would confer any benefit on Dr Chupin; the Tribunal concludes that there was nothing inherently dishonest in Dr Chupin changing the read code. Furthermore, the Tribunal reminds itself that it had found not proved the allegation in 10a, namely that he knew that no reference to back pain had been made during the consultation.

131. The Tribunal then moved on to consider whether his record of the consultation would be subject to scrutiny altered the situation and indicated a dishonest motive.

132. The Tribunal appreciates the arguments put forward by Ms Barbour on behalf of the GMC, namely that: Dr Chupin was in a panic; knew that his actions regarding Patient B would be scrutinised; knew that Mr C was unhappy with him as he had not called an ambulance; and that with hindsight he should have called an ambulance. Ms Barbour therefore maintained that Dr Chupin had a dishonest motive to cover up his actions and therefore altered the read code to minimise his clarification of Patient B's problem as back pain.

133. The Tribunal takes account of Dr Chupin's denials that this was his motivation and that he said that he did not know why or how he altered the read code, suggesting that it was by accident. Moreover, he has readily admitted that he made alterations to his actual record of the consultation so as to 'make the record more informative' which the Tribunal considers is acceptable.

134. The Tribunal relies once again on the expert evidence which confirms that the alteration to the read code could have been done by accident and, more importantly, that they could not see any benefit to Dr Chupin accruing to him.

135. Accordingly, the Tribunal considered that it was plausible, and more likely than not, that Dr Chupin could have altered the 'Low Back Pain' entry from 'active' to 'past' inadvertently and may not have noticed he had done so. It considers that Dr Chupin therefore has provided an innocent explanation for his actions in altering the read code and that ordinary decent people would not consider them to be dishonest. The Tribunal was therefore not satisfied on the balance of probabilities that Dr Chupin had a dishonest motivation for changing the Read code entry.

136. The Tribunal therefore found paragraph 11 not proved in respect of paragraph 9a as it relates to paragraph 10b.

137. In relation to paragraph 9a as it relates to paragraph 10c, the Tribunal considered whether altering the read code was dishonest because Dr Chupin knew that he was making a retrospective entry. However, the Tribunal notes that it had found that most likely Dr Chupin made the alteration to the read code accidentally so he would not have appreciated that he had actually altered the records, retrospectively or not. On that basis, the Tribunal finds paragraph 11 not proved in respect of paragraph 9a as it relates to paragraph 10b.

138. The Tribunal next considered whether Dr Chupin's additions to the Original Record was dishonest by reason of him: (i) knowing that his record keeping would be subject to

scrutiny and/or (ii) by virtue of him not noting that he had made a retrospective amendment to the Original Record.

139. The Tribunal first considered whether Dr Chupin's actions in adding additional detail which did not reflect the true content of the conversations he had had with Patient B and Mr C were inherently dishonest.

140. The Tribunal takes account of its findings regarding paragraphs 9b and 10b. It found that most of the additional details added by Dr Chupin were accurate; that the inaccurate entry regarding reference to Patient B's son was not significant; that there had been a significant time gap between the consultation and the amendments (about two and three-quarter hours) and that it was plausible that Dr Chupin likely had concentrated on the outcome of the consultation rather than recording all the details. Moreover, the Tribunal took account of the expert evidence that the additional detail was to the standard expected. Finally, the Tribunal takes account of its finding that paragraph 9b had been proved and that Dr Chupin had accepted that he had added further details because he knew that his record of consultation would be subject to scrutiny.

141. Taking all these factors into account together with the expert opinion about the potential for Dr Chupin to have concentrated upon the outcome rather than the details of the consultation, the Tribunal concludes that there is nothing inherently dishonest about Dr Chupin's actions.

142. The Tribunal then moved onto consider whether Dr Chupin's knowledge that his record keeping would be subject to scrutiny altered the situation and provided a dishonest motive.

143. The Tribunal took into account, once again, Ms Barbour's arguments as set out above together with Dr Chupin's denials of dishonesty and his confirmation that he made alterations to the record precisely because he knew that his account would be scrutinised.

144. The Tribunal also takes account of paragraphs 184, 185 and 187 of Mr Williamson's submissions, which it finds persuasive.

> *'184. If Dr Chupin had the intent and attention and recall required to be dishonest and cover his back as the GMC allege, when he came to edit the record after the final call with Mr C, Dr Chupin would surely have recorded something to the effect that he had advised referral to hospital was 'not a problem' – consistent with what he said during*

the call, as documented at [82] – or like adding his impression of slurred speech, he could have added his impression that an ambulance had not been needed at that time. He did not do so because he was only seeking to add information he thought would assist others coming to read his entry and not for any self-serving reason. Dr Chupin's evidence was clear – 'I was probably not registering what he was saying to me'.

185. That he did not go back and further edit the entry at or after 16:09 is consistent with Dr Chupin's explanation that he was deeply in shock and gave no clear or coherent thought whatsoever to the precise circumstances in which he made the entry or edited it, including by the time of [Dr E]'s investigation. The 16:09 entry was also demonstrably wrong in reference to there having been an 'Examination'.

…

187. The GMC suggested that Dr Chupin acted as he did 'to put something in the notes that would try to protect you from criticism'. If Dr Chupin had given a single thought to misleading subsequent readers of the records in that way, the Tribunal may think he would have not made so many obvious errors when making his entries. Yet more mistakes and yet another example of no conceivable dishonest motive…'

145. Taking all these factors together, the Tribunal concludes that the GMC has failed to demonstrate, on balance, that, when amending Patient B's records, Dr Chupin had a dishonest motive.

146. The Tribunal therefore found paragraph 11 not proved in respect of paragraph 9b as it relates to paragraph 10b.

147. The Tribunal next moved on to consider whether, in relation to paragraph 9b as it relates to paragraph 10c, Dr Chupin's knowledge that he was making a retrospective record and was therefore potentially obscuring the true content of the original report, was dishonest.

148. The Tribunal notes the reasons for finding paragraph 10c proved as set out above particularly in paragraphs 115 and 116. Consequently, it follows that Dr Chupin must have known that, as his alteration of the record of the consultation was deliberate, he was altering the record retrospectively and should have indicated this. It follows that Dr Chupin knew that what he was doing was wrong and against all good medical practice. The Tribunal is therefore

led to the conclusion that, as he continued to amend the entry without indicating that it was retrospective, ordinary decent people would conclude that his actions were dishonest.

149. The Tribunal therefore finds paragraph 11 proved in respect of paragraph 9b as it relates to paragraph 10c.

150. The Tribunal next considered paragraph 9ci, namely whether Dr Chupin's actions in failing to record that he was aware of Patient B's death at the time of his amendment was dishonest by reason of paragraphs 10b and 10c.

151. The Tribunal first considered whether failing to record that he was aware of Patient B's death was inherently dishonest. The Tribunal notes and accepts that Dr Chupin was shocked by Patient B's death, it also notes that he did subsequently record her death in the records, at 16:09, about 45 minutes after he completed the amendment to the consultation.

152. The Tribunal also notes that paragraph 9c alleges (by use of the word 'failed') that Dr Chupin had a duty to record, at the time of the amendments, that he was aware of Patient B's death, and that he has admitted this allegation. Furthermore, the Tribunal notes that Dr Chupin accepted that his motivation for amending the record was learning of Patient B's death.

153. Taking all of these factors into account, the Tribunal does not consider that simply failing to record at the time of the amendments that Patient B had died was inherently dishonest.

154. The Tribunal next went on to consider whether Dr Chupin's knowledge that his record of the consultation would be subject to scrutiny altered the situation and indicated a dishonest motive.

155. The Tribunal is particularly aware that Dr Chupin made the amendments precisely because Patient B had died. Accordingly, the Tribunal struggles to see how any dishonesty can be imputed to Dr Chupin by not referring to Patient B's death when amending the record. As a matter of good practice, it would have been preferable to refer to her death when making the amendment, but in the Tribunal's view, failing to refer to it does not invalidate those amendments since there was no allegation that Dr Chupin's actions during the consultation were in any way a contributory factor in her death.

156. Accordingly, the Tribunal finds not proved paragraph 11 in respect of Paragraph 9ci as it relates to paragraph 10b.

157. In relation to paragraph 9ci as it relates to paragraph 10c, the Tribunal considered whether Dr Chupin failing to record that he was aware of Patient B's death when making the amendments were dishonest because he had not referred to the amendment as retrospective.

158. The Tribunal considered that, as a matter of logic, Dr Chupin could not be criticised for failing to record that he was aware of Patient B's death, notwithstanding the relevant entry was retrospective, when no reference to her death was made in that amendment. The Tribunal therefore finds paragraph 11 not proved in respect of paragraph 9ci as it relates to paragraph 10c.

159. Finally, the Tribunal considered whether Dr Chupin's actions in failing to record that he was making a retrospective entry (as alleged in paragraph 9cii) was dishonest by virtue of paragraphs 10b and 10c.

160. The Tribunal notes that it has already found that Dr Chupin was dishonest when finding paragraph 11 proved in respect of paragraph 9b as it relates to paragraph 10c, simply on the basis that he should have recorded that he was making a retrospective entry.

161. The Tribunal repeats its reasoning in paragraphs 115 and 116 above and its finding that Dr Chupin failing to make a record that he was making a retrospective entry was dishonest. For the avoidance of doubt, the Tribunal confirms that it considers such to be inherently dishonest on the basis that he knew, or must have known, that what he was doing was wrong.

162. Accordingly, it follows that in any event the GMC has demonstrated on balance that Dr Chupin's actions at 9cii were dishonest by virtue of paragraphs 10b and 10c.

163. In respect of whether Dr Chupin's actions at 9cii were dishonest by virtue of paragraph 10b, as it has found that Dr Chupin had no dishonest motive in relation to paragraph 10b, it follows that failing to record that that he was making a retrospective entry is not dishonest "by virtue of" Dr Chupin's knowledge that his record keeping would be scrutinised – it is dishonest solely due to paragraph 10c. It therefore follows that the GMC

has failed to demonstrate on balance that Dr Chupin's actions at 9cii were dishonest by virtue of paragraph 10b.

164. Accordingly, paragraph 11 is not proved in respect of paragraph 9cii as it relates to paragraph 10b but is proved in respect of paragraph 9cii as it relates to paragraph 10c.

The Tribunal's Overall Determination on the Facts

165. The Tribunal has determined the facts as follows:

Patient A

1. On 28 October 2020, you undertook a telephone consultation with Patient A and you:

    a. failed to take an adequate history in that you did not elicit information about:

        i. a detailed history of pain; **Admitted and found proved**

        ii. any associated 'red flag' symptoms; **Admitted and found proved**

        iii. any bilateral pain; **Admitted and found proved**

        iv. saddle numbness; **Admitted and found proved**

        v. any associated sphincter disturbance causing bladder symptoms; **Admitted and found proved**

        vi. any associated sphincter disturbance causing bowel symptoms; **Admitted and found proved**

    b. failed to sufficiently explore significant symptoms; **Admitted and found proved**

    c. unreasonably focussed upon one symptom; **Admitted and found proved**

    d. failed to provide an adequate differential diagnosis for Patient A's condition; **Admitted and found proved**

e. failed to determine whether Patient A needed to be further assessed at a face-to-face appointment; **Admitted and found proved**

f. failed to consider the possibility that the back pain could be a result of malignancy; **Admitted and found proved**

g. failed to provide adequately detailed safety netting advice to Patient A; **Admitted and found proved**

h. failed to make an adequate record of the consultation in that you did not refer to the following reported symptoms:

i. breathlessness; **Admitted and found proved**

ii. weight loss; **Admitted and found proved**

iii. nausea (from taking Tramadol); **Admitted and found proved**

iv. fatigue. **Admitted and found proved**

2. In your record of the consultation, you noted that you had advised Patient A:

a. 'on… manual handling'; **Admitted and found proved**

b. 'on… rest'; **Admitted and found proved**

c. 'to avoid heavy lifting'; **Admitted and found proved**

d. 'to call us back if any red flags'. **Admitted and found proved**

3. You knew that during the consultation, you had not given any substantive advice on:

a. manual handling; **Not proved**

b. rest; **Not proved**

c. avoiding heavy lifting; **Not proved**

d. relevant red flag symptoms. **Not proved**

4. Your actions as set out at:

a. paragraph 2a were dishonest by reason of paragraph 3a; **Not proved**

b. paragraph 2b were dishonest by reason of paragraph 3b; **Not proved**

c. paragraph 2c were dishonest by reason of paragraph 3c; **Not proved**

d. paragraph 2d were dishonest by reason of paragraph 3d. **Not proved**

Patient B

5. On 13 July 2021, you undertook a telephone consultation with Patient B, and subsequently spoke to her partner, Mr C, and you:

   a. failed to elicit an adequate history from Patient B's partner, Mr C, in that you failed to enquire about:

      i. falls or trauma to the back; **Admitted and found proved**

      ii. any radiation of pain into the legs; **Admitted and found proved**

      iii. any neurological symptoms; **Admitted and found proved**

   b. failed to adequately assess Patient B's presenting condition; **Admitted and found proved**

   c. failed to arrange a face-to-face consultation with Patient B; **Admitted and found proved**

   d. failed to provide an adequate differential diagnosis for Patient B's Admitted condition; **Admitted and found proved**

   e. failed to formulate an adequate management plan; **Admitted and found proved**

   f. failed to provide adequate safety-netting advice; **Admitted and found proved**

   g. inappropriately prescribed:

      i. Nefopam; **Admitted and found proved**

      ii. Tramadol; **Admitted and found proved**

6. In your original record of the consultation with Patient B and Mr C ('the Original Record'), as reproduced at Schedule 1, you:

   a. failed to record the involvement of Mr C in your assessment and/or management of Patient B; **Admitted and found proved**

   b. noted that Patient B:

      i. had not suffered "recent falls"; **Admitted and found proved**

      ii. 'asked for stronger pain killers'; **Admitted and found proved**

      iii. was 'happy with the [treatment] plan'. **Admitted and found proved**

7. You knew that during the consultation:

   a. you had not asked, or been told about, whether Patient B had suffered any recent falls; **Not proved**

   b. Patient B did not request painkillers; **Determined and found proved**

   c. you had not spoken directly with Patient B about your proposed treatment plan; **Determined and found proved**

   d. Mr C had expressed a view to you that Patient B should be admitted to hospital due to ongoing serious pain. **Determined and found proved**

8. Your actions were dishonest as set out at:

   a. paragraph 6(b)(i) by reason of paragraph 7(a); **Not proved**

   b. paragraph 6(b)(ii) by reason of paragraph 7(b); **Not proved**

   c. paragraph 6(b)(iii) by reason of paragraph 7(c)-7(d). **Not proved**

9. Having learned of Patient B's death on 13 July 2021 you amended the Original Record and, in that amended record, as reproduced at Schedule 2, you:

   a. altered the read code entry of 'Low Back Pain' from an 'active' to a 'past' problem; **Admitted and found proved**

b. added additional detail, which did not fully reflect the true content of the conversations you had with Patient B and Mr C; **Determined and found proved**

c. failed to record that you:

i. had been made aware of Patient B's death at the time of your amendments; **Admitted and found proved**

ii. were making a retrospective entry/amendment to the record. **Admitted and found proved**

10. When you altered the Original Record you knew that:

a. during the consultation neither Patient B nor Mr C had made reference to low back pain; **Not proved**

b. your record keeping of your consultation with Patient B and Mr C would be subject to scrutiny; **Determined and found proved**

c. by virtue of you not noting that you had made a retrospective amendment to the record, the true content of the Original Record was potentially obscured. **Determined and found proved**

11. Your actions as set out at paragraph 9 were dishonest by reason of paragraph 10. **Determined and found proved in respect of paragraph 9b as it relates to paragraph 10c, and paragraph 9cii as it relates to paragraph 10c.**

Determination on Impairment - 13/08/2024

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

The Evidence

167. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, the Tribunal received further evidence as follows:

- Dr Chupin's CPD including Certificates of Completion/Attendance for the following courses:
    - Telephone Consultation and Triage Skills, 14 September 2021;
    - Dealing with Challenging Patients in Primary Care, 10 October 2021;
    - Good Record-Keeping, 10 October 2021;
    - Advance Decisions and DNACPR, 10 October 2021;
    - Telephone Consultation Skills and Triage Training, 3 November 2021;
    - GP Update Online Course (and agenda), Autumn 2021/Winter 2022;
    - Remote Consulting, 26 February 2022;
    - Managing medicines in alcohol-associated liver disease, 10 March 2022;
    - NICE guidelines on chronic pain, 13 March 2022;
    - Alcohol Misuse, 27 March 2022;
    - Good Practice When Prescribing, 1 September 2022;
- Letter confirming Dr Chupin's role as Clinical Cancer Champion for the Practice, 23 January 2022;
- Letter from NHSE Complaints Team to Complainant in relation to Patient B, 4 March 2022;
- Clinical Meeting Minutes, 16 March 2022;
- Three Supervision Reports of Dr G, 16 January 2023, 18 July 2023 and 27 March 2024;
- Responsible Officer Statement, 24 May 2024.

Submissions

On behalf of the GMC

168. On behalf of the GMC, Ms Barbour submitted that Dr Chupin's fitness to practise is impaired by virtue of his misconduct.

169. Ms Barbour reminded the Tribunal of the two-stage process to be followed; first to establish whether there had been any misconduct, which must be serious and then, to determine whether that serious misconduct led to the conclusion that Dr Chupin's fitness to practise was impaired. Ms Barbour cited the relevant case law that defined the word *'misconduct'.*

170. Ms Barbour referred the Tribunal to the summary of the expert witnesses' joint report dated 30 October 2023. She submitted that in respect of Patient A, the experts agreed

that the matters alleged, admitted and found proved at paragraphs 1(a)-(h)(iv) inclusive of the Allegation, demonstrated that the care provided was seriously below the expected standard.

171. In respect of paragraphs 2(a)-(d), Ms Barbour drew the Tribunal's attention to the expert witnesses' conclusions that the record made by Dr Chupin *"was not in fact representative of advice given by Dr Chupin to Patient A. This record was inaccurate and this record keeping was seriously below the standard expected".* Ms Barbour submitted that in respect of paragraphs 1(a)-(h)(iv) inclusive and paragraphs 2(a)-(d), these matters amounted to misconduct.

172. In relation to Patient B, Ms Barbour submitted that the joint view of the expert witnesses was that if the record accurately reflected Dr Chupin's actual thoughts at the time, that is to say, if Dr Chupin had genuinely been thinking that Patient B was suffering from backache rather than him mistakenly making a note about backache, then the failure to elicit an adequate history from Patient B's partner as set out at paragraphs 5(a)(i)-(iii) meant that the care was seriously below the expected standard. In respect of paragraphs 5(b)-(g)(ii) and allegation 6(a)-(b)(iii), the experts agreed that the care fell seriously below the expected standard and, therefore, amounted to misconduct.

173. Ms Barbour then moved on to paragraphs 7(b)-(d) of the Allegation and directed the Tribunal to the joint expert assessment in which the experts noted that the record made by Dr Chupin *"was not in fact representative of the history taken by Dr Chupin from Patient B or Mr C. The experts agreed that it was the case that Dr Chupin ought to have known that he did not take this history, and then recorded that he had done so. This record was inaccurate and this record keeping was seriously below the standard expected".* Ms Barbour submitted, therefore, that this amounted to misconduct.

174. Ms Barbour acknowledged that the Tribunal had found paragraph 9(a) of the Allegation proved. She submitted that, despite this, given the factual basis upon which this finding was made namely, that it was likely done by accident, there could be no proper grounds to argue that this amounted to serious professional misconduct.

175. When addressing paragraph 9(b), Ms Barbour reminded the Tribunal of its findings at the previous stage that the addition of extra detail did not fully reflect the true content of Dr Chupin's conversations with Patient B and Mr C. It was dishonest by virtue of Doctor Chupin not noting that he had made a retrospective amendment to the record, thus potentially

obscuring the true content of the record. As set out by the Tribunal in its previous determination, *"Dr Chupin knew what he was doing was wrong and against all good medical practice".* Ms Barbour submitted that for Dr Chupin to behave in this way, despite knowing it was wrong and against good medical practice was a flagrant and deliberate breach of good medical practice, and amounted to very serious professional misconduct.

176. Ms Barbour submitted that the record-keeping in both paragraphs 9(c)(i) and (ii) of the Allegation had been deemed as seriously below the expected standard by the expert witnesses. The actions as set out in paragraph 9(c)(i), therefore, amounted to *'clinical'* misconduct. However, given the Tribunal's reasoning in its previous determination, there was no submission that there was anything in addition to that which would amount to serious professional misconduct by reason of motivation for the failure.

177. Ms Barbour submitted that the allegation at paragraph 9(c)(ii) was a different matter. The Tribunal had found Dr Chupin's failure to record that he was making a retrospective entry or amendment to the record was dishonest by virtue of his knowledge that the record keeping of his consultation with Patient B and Mr C would be subject to scrutiny, and was also dishonest by virtue of Dr Chupin not noting that he had made a retrospective amendment to the record, thus potentially obscuring the true content of the record. The Tribunal had found this to be inherently dishonest and found that Dr Chupin knew, or must have known, that what he was doing was wrong. Ms Barbour submitted that to behave in this way, despite knowing what he was doing was wrong, amounted to very serious professional misconduct.

178. The Tribunal pauses there to confirm that, having noted this submission from Ms Barbour, it has issued an addendum to the Facts determination clarifying that it had not, in fact, found that *"Dr Chupin's failure to record that he was making a retrospective entry or amendment to the record was dishonest by virtue of his knowledge that the record keeping of his consultation with Patient B and Mr C would be subject to scrutiny".* The addendum confirmed that the Tribunal had only found dishonesty in relation to Dr Chupin not indicating that the amendment was retrospective.

179. Turning to paragraphs 10(b) and (c) of the Allegation, Ms Barbour reminded the Tribunal of its findings at the previous stage and the joint expert opinion that the record-keeping was seriously below expected standards. Ms Barbour submitted these findings were also relevant to the findings of dishonesty and part of a wider factual picture and also

reminded the Tribunal of Dr Chupin's struggle to answer questions about the perils of failing to mark an entry as retrospective.

180. Ms Barbour submitted the following paragraphs of *Good medical practice* (2013 version) ('GMP') were engaged in this case:

> *1 Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.*
>
> *7 You must be competent in all aspects of your work ….*
>
> *15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*
>
> > *a. adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
> >
> > *b. promptly provide or arrange suitable advice, investigations or treatment where necessary*
> >
> > *c. refer a patient to another practitioner when this serves the patient's needs.*
>
> *16 In providing clinical care you must:*
>
> > *a. prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs*[6]
> >
> > *b. provide effective treatments based on the best available evidence*
> >
> > *c. take all possible steps to alleviate pain and distress whether or not a cure may be possible*
> >
> > *d. consult colleagues where appropriate*
> >
> > *e. respect the patient's right to seek a second opinion*
>
> *18 You must make good use of the resources available to you.*

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

b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions

c. the information given to patients

d. any drugs prescribed or other investigation or treatment

e. who is making the record and when.

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

68 You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.

71 You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading.

a. You must take reasonable steps to check the information is correct.

b. You must not deliberately leave out relevant information.

181. Ms Barbour reminded the Tribunal of guidance provided by Dame Janet Smith in the *Fifth Shipman Report*, as adopted by the High Court in *CHRE v NMC and Paula Grant* [2011] EWHC 297 Admin and submitted that each of the limbs was engaged in this case.

182. Ms Barbour cited further case law relevant to the matter of impairment. She submitted that the Tribunal must look carefully at the evidence of any action taken by Dr Chupin to remedy deficiencies and assess his current abilities and skills. Ms Barbour submitted that, for the Tribunal to be satisfied that Dr Chupin's fitness to practise is not currently impaired, it would need to be satisfied that the risk of repetition of the same conduct is very low. Mere words or embarrassment were insufficient, as was regret.

183. Ms Barbour submitted that Dr Chupin had shown little insight into his actions and the impact on his patients, colleagues, the profession as a whole and the wider public. Dr Chupin's position was that it was his XXX that led to his misconduct. However, there had been no findings in relation to XXX at the time that would have provided a context. Ms Barbour submitted it was a fact that many doctors are exhausted. However, they maintained the expected standards and did not compromise their ethics.

184. Ms Barbour reminded the Tribunal it must give sufficient weight to the statutory overarching objective and that the reputation of the profession as a whole was more important than the interests of the individual doctor. Ms Barbour turned to the matter of dishonesty and referred the Tribunal to the case of *Sawati* which provides that the Tribunal is not entitled to hold a denial of dishonesty, which was subsequently found proved, against a doctor.

185. Ms Barbour took the Tribunal through the CPD and testimonials provided by Dr Chupin. Ms Barbour invited the Tribunal to look at the dates on the certificates and submitted that there had been limited work done more recently. Dr Chupin's reflections seemed to address the clinical failings but not the matter of dishonesty. Ms Barbour acknowledged that the content of the testimonials showed Dr Chupin to be someone capable of decent clinical work. However, they had been written by authors who did not know of the Tribunal's findings of dishonesty.

186. Ms Barbour submitted that any concern about Dr Chupin's level of insight and risk of repetition should lead to a finding that Dr Chupin's fitness to practise is currently impaired. In any event, the nature and seriousness of the misconduct in this case was such that a finding of current impairment would be required to maintain public confidence in the profession.

On behalf of Dr Chupin

187. On behalf of Dr Chupin, Mr Williamson submitted that there was no dispute with most of the aspects of Ms Barbour's submissions, and Dr Chupin did not contest the matter of misconduct or impairment.

188. Mr Williamson invited the Tribunal to scrutinize the evidence and to have a particular regard to what it had been told, including the evidence of the experts.

189. Mr Williamson submitted that Dr Chupin had shown a great deal by way of understanding the impact of his behaviour and failings on his patients, colleagues, the profession a whole, and the wider public interest. His remorse, shame and regret were explained by these factors and Dr Chupin had never tried to excuse his misconduct. Mr

Williamson reminded the Tribunal that the index events were now more than three years old; this did not take away from the seriousness of them but was relevant to the Tribunal's considerations of the doctor at this time.

190. Mr Williamson told the Tribunal that Dr Chupin had demonstrated insight. He submitted that this was evidenced by Dr Chupin's early and full admissions in all material respects. Dr Chupin had cooperated with the various investigations and expressed regret and remorse, including an expression of apology to Mr C.

191. Mr Williamson cited the case law which, he submitted, was relevant in this case in relation to the definition of misconduct. Mr Williamson told the Tribunal that Dr Chupin had never sought to suggest he had not made elementary failures in his treatment of Patient A and Patient B and the finding of misconduct was a serious finding which served a public interest purpose in and of itself.

192. Mr Williamson submitted that the Tribunal's task was to separate the various relevant factors and question whether, in light of those factors, Dr Chupin's fitness to practise is impaired. Public confidence in the profession was important and the Tribunal's decision must reflect the views of an informed, reasonable member of the public. The Tribunal was well placed to do this, having heard so much evidence including that of the expert witnesses.

193. Mr Williamson submitted that Dr Chupin did not seek to play down the gravity of his conduct. He talked the Tribunal through the steps Dr Chupin had taken to remediate and reflect on his clinical failings and told the Tribunal that Dr Chupin regarded dishonesty as deplorable. Dr Chupin understood the seriousness of the Tribunal's findings in relation to dishonesty and the impact of that. Mr Williamson referred the Tribunal to Dr G's reports that Dr Chupin was working to a satisfactory level and there were no concerns.

194. Mr Williamson stated that Dr Chupin recognised it was a fundamental tenet of medical practice that a doctor must make clear when they have made a retrospective entry in a medical record. He invited the Tribunal to look back at the evidence and it would see that Dr Chupin had accepted the profound impact of these regulatory proceedings and that they acted as a salutary lesson. Mr Williamson submitted that if faced with a similar situation, Dr Chupin would not repeat the behaviour. Only that morning, Dr Chupin had said to him, *"Never again in my life".*

195. Mr Williamson submitted that Dr Chupin had never suggested his conduct could be excused; the dishonesty finding was very serious and engaged the public interest. What Dr Chupin had done was to ensure this would never happen again by reflecting on the issues that led to the clinical failings and remedying the gaps in his practice to Dr G's satisfaction, making it highly unlikely the errors would be repeated. Dr Chupin had instructed receptionists to send screen messages rather than calling him, to avoid being distracted, and the receptionists were not to interrupt during consultations other than in an emergency. Other changes Dr Chupin had put in place included documenting during, or immediately after, consultations to avoid any risk of misunderstanding during consultations, and accessing online tools to assist with either diagnostics or management.

196. Mr Williamson submitted that the Tribunal could be satisfied there was no risk of repetition.

The Relevant Legal Principles

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

198. In approaching its decision, the Tribunal was mindful of the two stage process to be adopted: first whether the facts as found proved amounted to misconduct and that the misconduct was serious and then whether the finding of that misconduct which was serious could lead to a finding of impairment.

199. The Tribunal reminded itself of the statutory overarching objective 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 the profession.

200. In relation to misconduct, the Tribunal bore in mind the case of *Roylance v General Medical Council (No.2)* [2000] 1 A.C. 311, which provides:

> *'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.'*

201. The misconduct must involve the doctor falling not just short, but far short, by omission or commission, of the standards of conduct expected of a General Practitioner.

202. In assessing seriousness, the Tribunal is entitled to take account of the fact that, in the Sanctions Guidance, dishonesty is regarded as a particularly serious matter. Moreover, in relation to the clinical findings, the Tribunal is entitled to pay heed to the expert opinions of Dr H and Dr I.

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

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

204. The Tribunal had regard to paragraph 74 of *Grant* which states

> *'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.'*

205. The Tribunal must determine whether Dr Chupin's fitness to practise is impaired today, taking into account Dr Chupin's conduct at the time of the events and any relevant

factors since then such as whether the matters are remediable, have been remedied and any likelihood of repetition.

206. The Tribunal took into account of paragraph 94 of the case of *GMC v Sawati* [2022] EWHC 283 (Admin) which states:

> *"94. The High Court recently reviewed the principles to be derived from the 'rejected defence' authorities on the question of 'denial of allegations, insight and sanctions' in Sayer v General Osteopathic Council [2021] EWHC 370 (Admin) at paragraph 25 as follows:*
>
> *(1) Insight is concerned with future risk of repetition. To this extent, it is to be distinguished from remorse for the past conduct.*
> *(2) Denial of misconduct is not a reason to increase sanction.*
> *(3) It is wrong to equate maintenance of innocence with lack of insight. Denial of misconduct is not an absolute bar to a finding of insight. Admitting misconduct is not a condition precedent to establishing that the registrant understands the gravity of the offending and is unlikely to repeat it.*
> *(4) However, attitude to the underlying allegation is properly to be taken into account when weighing up insight. Where the registrant continues to deny impropriety, that makes it more difficult for him to demonstrate insight.*
> *(5) The assessment of the extent of insight is a matter for the tribunal, weighing all the evidence and having heard the registrant. The Court should be slow to interfere."*

The Tribunal's Determination on Impairment

Misconduct

207. In determining whether Dr Chupin's fitness to practise is impaired by reason of misconduct, the Tribunal first considered whether the facts found proved amounted to misconduct. The Tribunal had regard to the expert witness joint report in conjunction with Ms Barbour's submissions throughout its deliberations. The Tribunal confirms that it accepts Ms Barbour's submissions regarding the GMP.

208. When considering paragraph 1 of the Allegation, the Tribunal took into account that both experts agreed all the clinical failures admitted and found proved in particulars 1(a)-(h)(iv) fell seriously below the standards expected of a doctor. The Tribunal accepted the

conclusions of the expert witnesses, and therefore found Dr Chupin's failings during the telephone consultation with Patient A amounted to misconduct that was serious.

209. The Tribunal took into account that the expert witnesses were in agreement that paragraph 2 of the Allegation was factually correct and that the record-keeping of the consultation fell seriously below the standards expected of a doctor. The Tribunal also had regard to Ms Barbour's submissions and determined that keeping such an inaccurate record amounted to misconduct that was serious.

210. The Tribunal then turned to the matters as set out at paragraph 5(a)(i-iii) of the Allegation. It accepted the agreed opinion of both expert witnesses that Dr Chupin's recorded diagnosis of back pain could have been made erroneously and weighed this against Dr Chupin's evidence that he had thought it was back pain. The Tribunal considered the two options presented, depending on its preferred version of events. It was of the view that Dr Chupin had mistakenly made a note of back pain while trying to recall the consultation as he considered back pain as a differential diagnosis. The Tribunal therefore concluded that the failure to elicit such information from Mr C amounted to misconduct that was serious.

211. In respect of the remainder of paragraph 5 of the Allegation, and also paragraph 6, the Tribunal again had regard to the joint expert witness report. Both experts agreed that all the clinical failures identified, admitted and found proved, fell seriously below the standards expected of a doctor. The Tribunal accepted their evidence and therefore found Dr Chupin's standard of care amounted to misconduct that was serious.

212. The Tribunal was also persuaded by Ms Barbour's submission in relation to paragraphs 7(b)-(d) of the Allegation and, applying the argument presented in the submissions, determined that Dr Chupin's actions as set out amounted to misconduct that was serious.

213. The Tribunal then proceeded to consider paragraph 9 of the Allegation. In regard to paragraph 9(a), the Tribunal noted its earlier decision that the alteration of the read code entry could have been made accidentally and, therefore, determined that this did not amount to misconduct.

214. The Tribunal had regard to its findings in relation to paragraph 9(b), that the addition of the extra detail did not fully reflect the true content of the conversations with Patient B, and concluded that Dr Chupin's conduct amounted to misconduct that was serious.

215. In its consideration of paragraph 9(c)(i) and (ii) of the Allegation, the Tribunal had regard to the opinions of the expert witnesses who agreed that, in any event, the matters were clinical failures that fell seriously below the standards expected of a doctor. The Tribunal agreed. Further, it reminded itself that, when determining paragraph 9(c)(ii), the Tribunal found that Dr Chupin's actions were dishonest and therefore amounted to misconduct that was serious.

216. The Tribunal had regard to its findings at the previous stage and the conclusions of the expert witnesses when determining paragraphs 10(b) and (c) of the Allegation. It agreed with the expert opinions that Dr Chupin's actions fell seriously below the standards expected of a doctor. The Tribunal determined, therefore, that the behaviour as outlined in these paragraphs amounted to misconduct that was serious.

217. The Tribunal then considered paragraph 11 of the Allegation and had regard to its findings of dishonesty at the previous stage. The Tribunal concluded that Dr Chupin's dishonesty in respect of paragraphs 9(b) and 9(c)(ii) by reason of paragraph 10(c) amounted to misconduct that was serious. On this point, the Tribunal again reminds the parties regarding the addendum to the Facts determination.

218. The Tribunal has concluded that most of Dr Chupin's conduct fell so far short of medical standards reasonably to be expected of a doctor as to amount to misconduct. In conclusion, the Tribunal found that all the matters found proved, with the exception of paragraph 9(a), amounted to misconduct.

Impairment

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

220. The Tribunal first had regard to the test for impairment as set out in *Grant* and concluded that all four factors were engaged at the time of the events.

221. In determining whether a finding of current impairment of fitness to practise was necessary, the Tribunal looked for expressions of remorse or regret, evidence of insight and remediation, and considered the likelihood of repetition, having regard throughout to the

overarching statutory objective. The Tribunal acknowledged that it can often be difficult for a practitioner to fully remediate in cases of dishonesty, particularly where allegations of dishonesty have been denied.

222. The Tribunal took into account the remorse exhibited by Dr Chupin. It was of the view that Dr Chupin understood some of what went wrong and had realised he should have asked different questions and made better records. He had indicated that he thought it was embarrassing, and found it painful, to listen to the recordings of the telephone conversations. The Tribunal was satisfied that Dr Chupin has some appreciation of what went wrong and that he should have acted differently but he had yet to demonstrate the thought process that led to making the retrospective entries and his understanding of how the retrospective notes could affect continuity of patient care and the ability to respond fully to any complaints.

223. The Tribunal also had regard to Dr Chupin's evidence about how he should act differently in the future in relation to XXX. He had demonstrated an awareness of how XXX may play in his ability to deliver good medical care but had indicated that, notwithstanding his previous experiences XXX, he still would not tell anybody about such if it reoccurred. The Tribunal considered that this gave rise to concerns regarding how he would manage any future XXX difficulties. In conclusion, the Tribunal considered Dr Chupin's level of insight to be developing but not full, into both his clinical and dishonesty failings.

224. The Tribunal considered that all the clinical matters were capable of being remedied and accepted that dishonesty is more difficult. However, looking at where Dr Chupin's isolated case of dishonesty appeared on the spectrum of dishonesty, it was apparent to the Tribunal that it was at the lower end of the spectrum. Further, the Tribunal accepted that it was arguable that, as Dr Chupin made a dishonest decision in the moment, this case was more about a dishonest act rather than a fundamental character trait.

225. The Tribunal had regard to the body of CPD evidence provided by Dr Chupin. He had clearly done some remediation by attending courses and reading but there was no reflection from Dr Chupin outlining how he had taken the learnings and applied them in his everyday practice, and/or how this had assisted him and changed his practice. The Tribunal noted that the courses were historical, with nothing up-to-date that addressed all of the matters referred to in the Allegation. The Tribunal acknowledged that Dr Chupin seemed willing to remediate and improve his practice, and had answered all questions asked of him. It was of the view that Dr Chupin was on the road to remedying his failings but there was still some work to be done.

226. The Tribunal took into account the reports of Dr G, Dr Chupin's current clinical supervisor. She confirmed there were no concerns and that Dr Chupin was continuously improving. The Tribunal also had regard to the eight testimonials provided on behalf of Dr Chupin. These were written in September and October of 2023, with one testimonial from February 2023, and came from a variety of medical professionals who have worked with, or currently work with, Dr Chupin, including his current practice manager. The Tribunal noted the content of the testimonials referred to Dr Chupin's reliability, clinical competence, honesty and integrity. However, although the Tribunal found the testimonials helpful it did not place great weight on them as they were not up-to-date and not written with the knowledge of the findings of dishonesty.

227. The Tribunal considered the risk of repetition of the serious misconduct. It was of the view that having been through this regulatory process, it was arguable that Dr Chupin was unlikely to repeat the actions that led to this hearing. The Tribunal took into account that Dr Chupin was someone who, up until now, was of good character and there had been no concerns either prior to, or after, these two isolated incidents. However, the Tribunal was concerned that Dr Chupin had indicated he may not XXX or ask for help in the future and was not satisfied that Dr Chupin would ensure XXX if a similar situation arose again.

228. The Tribunal also had regard to the fact that the remediation Dr Chupin had undertaken related to his clinical failings but there were no reflections on the Tribunal's findings of dishonesty, although it accepted that Dr Chupin had not had much opportunity to reflect. The Tribunal was of the view that until Dr Chupin was able to demonstrate a satisfactory level of insight and reflection into the conduct that was found to be dishonest, there remained a small risk of repetition.

229. The Tribunal considered its findings of dishonesty in this case indicated a deliberate failure to apply fundamentals of GMP. While the Tribunal accepted that this had been a single, isolated incident, a finding of dishonesty was a matter serious enough to find impairment on public interest and public protection grounds.

230. In all the circumstances, the Tribunal was satisfied that Dr Chupin's fitness to practise is currently impaired, notwithstanding the passage of time since the events in question and that the dishonesty involved a single incident. Further, the Tribunal was of the view that given its finding of serious misconduct and the lack of insight, a reasonably informed member of the public would be concerned if a finding of impairment were not made.

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

Determination on Sanction - 29/10/2024

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

The Evidence

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

234.The Tribunal received further evidence on behalf of Dr Chupin including:

- Updated testimonials from previous testimonial witnesses;
- Various CPD certificates, dated September 2024;
- Supervision report of Dr G, dated 12 September 2024; and
- Emails from Dr G dated 2 and 28 October 2024.

Submissions

On behalf of the GMC

235. On behalf of the GMC, Ms Barbour submitted that the appropriate outcome in this case is for an order of suspension to be imposed. Ms Barbour submitted that the clinical misconduct in this case has been found in respect of two different patients, many months apart, where there was a raft of clinical failings which fell seriously below the expected standard and amounted individually and cumulatively to serious professional misconduct. She further reminded the Tribunal that the dishonesty in this case was limited to Dr Chupin's failure to indicate that the amendments made were retrospective, and that it had found his actions to be a breach of Good Medical Practice (2013, as amended) ('GMP').

236. With regard to the determination on impairment, Ms Barbour reminded the Tribunal that it has expressed concerns about Dr Chupin's management of any future XXX problems which ultimately remained unresolved and as such there remained a risk of repetition. She further noted that the dishonesty had been categorised at the lower end of the spectrum and

had occurred as a dishonest decision "*in the moment*" rather than a fundamental character trait. Finally, she noted that the Tribunal has found that Dr Chupin was on the road to remedying his failings but that there was still work to be done and a small risk of repetition remained.

237. Ms Barbour submitted that the following mitigating factors apply in this case: a finding of partial insight and limited reflection; there have been no previous findings against Dr Chupin; Dr Chupin was a newly qualified GP at the time, although she noted this cannot justify dishonesty or a breach of the fundamental building blocks of practice; personal matters including work-related stress and XXX; and that four years have elapsed with no evidence of repetition. Turning to the matter of insight, Ms Barbour submitted that Dr Chupin has expressed himself very well throughout these proceedings, notwithstanding that English is not his first language. She further submitted that the Tribunal has categorised Dr Chupin as being at the start of his journey of developing insight and although he has now provided a reflective statement setting out what he has learnt from his CPD courses and his different approach to XXX, this is very recent documentation and "*largely untested*". She submitted that Dr Chupin has not shown "*mature insight*" and the Tribunal should weight this in the balance when determining the appropriate sanction in this case.

238. Ms Barbour submitted that the aggravating feature in this case is Dr Chupin's lack of timely insight. She submitted that Dr Chupin has managed to make further progress towards insight and remediation, but this has occurred during the hearing process.

239. Ms Barbour submitted that the misconduct in this case has been characterised as a single and isolated episode of dishonesty. She further submitted that the amendments to Patient B's records were made at a time when Dr Chupin was in shock, was XXX and struggling to concentrate, and in a state of panic. She submitted that while dishonesty is at the upper end of the spectrum in terms of seriousness of misconduct, and this is made more serious by virtue of it being a dishonesty amendment to a deceased patient's records, it was found to be an isolated incident, and not pre-meditated. She submitted that while this represents an extremely serious breach of GMP, it is not fundamentally incompatible with continued registration.

240. Turning to the available sanctions, Ms Barbour submitted that taking no action would not be appropriate as there are no exceptional circumstances present. She further submitted that conditions would not be appropriate because Dr Chupin does not have complete insight

and because no conditions could be drafted to meet the concerns surrounding probity, or assuage the risk to public confidence in the profession.

241. With regard to suspension, Ms Barbour submitted that there has been some acknowledgement of fault in this case, despite Dr Chupin's earlier denial, which should not be held against him. She further submitted that a lack of acknowledgement of fault at the facts stage is a factor which the Tribunal is entitled to weigh in the balance when considering insight. She submitted that this supports the submission that conditions would be inappropriate and insufficient to meet the overarching objective in this case. Ms Barbour submitted that erasure would not be the appropriate sanction in this case, but the concerns around public confidence in the profession confirms that conditions would be entirely inappropriate and reinforces the case for the imposition of an order of suspension.

242. In summary, Ms Barbour submitted that Dr Chupin's behaviour amounts to a number of serious breaches of GMP, demonstrating the wide-ranging nature of the serious concerns. She submitted that dishonesty, in a clinical setting, conflicts with the special position he held as a doctor. She submitted that this misconduct is extremely serious but falls just short of being fundamentally incompatible with continued registration. She submitted that the insight so far demonstrated falls short of what would be required to assuage grave concerns about the damage which Dr Chupin's actions have caused to public confidence in the profession. She submitted that, for all those reasons, an order of suspension must be imposed if the overarching objective is to be met.

On behalf of Dr Chupin

243. On behalf of Dr Chupin, Mr Williamson submitted that a short period of suspension is the appropriate sanction in this case. He submitted that a period of suspension need not be imposed in respect of Dr Chupin's clinical failings because he has been subject to interim conditions for several years now and has taken steps to address his clinical failings and deficient performance over a considerable period, such that a sanction is not necessary.

244. Mr Williamson submitted that Dr Chupin understands that a suspension is justified because it is an appropriate response to misconduct that is so serious that action must be taken to maintain public confidence in the profession. He submitted that Dr Chupin knows that it is his actions alone that have resulted in these proceedings and ultimately no one other than himself is responsible. Nonetheless, it has been an incredibly difficult time for him. He submitted that Dr Chupin has had considerable time to consider and reflect upon his

failings, his misconduct, and the Tribunal's findings. He submitted that these events have acted as a salutary lesson for Dr Chupin, and he is now a reflective, insightful and remediated doctor.

245. Turning to the mitigating factors in the case, Mr Williamson submitted the following factors are present: Dr Chupin understands the problem and has insight; he has attempted to address and remediate the problems; he admitted his clinical failings at an early stage; he has apologised; he has adhered to important principles of GMP; he is of previous good character; there is no evidence of repetition since the incidents; there were stressful circumstances leading up to the events in his personal life in that he was suffering with XXX and work-related stress; and considerable time has now passed since the two incidents. Mr Williamson submitted that Dr Chupin now understands the importance of being open and honest. Further, Dr Chupin cooperated with the investigation and has demonstrated that he has kept his skills and knowledge up to date so as to improve the quality of his work and promote patient safety.

246. Turning to aggravating factors, Mr Williamson reminded the Tribunal that it should take care not to double count factors which are part of the misconduct itself and matters which may be, in other contexts, treated as 'aggravating'. He further submitted that, while Dr Chupin's misconduct was plainly a serious breach of GMP, the clinical issues occurred on two different dates and the dishonesty related to Dr Chupin's professional role.

247. Considering the available sanctions, Mr Williamson submitted that conditions have been workable, and supervision has been an appropriate way to address the concerns identified. He submitted that Dr Chupin has complied with those conditions and remains willing to be open and honest with patients and colleagues if things go wrong, including with XXX.

248. With regard to suspension, Mr Williamson submitted that Dr Chupin does not need any further deterrent and that the proceedings themselves have been a salutary lesson for him. He further submitted that, while suspension would have a punitive and financial impact upon Dr Chupin, he recognises the fundamental importance of the public interest. He submitted that Dr Chupin recognises this is a case where suspension would plainly be an appropriate response to his misconduct, it being misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. He further submitted that this is misconduct which is serious but falls short of being fundamentally incompatible with continued registration.

249. Mr Williamson submitted that this is behaviour which is unlikely to be repeated as Dr Chupin has taken steps to remediate his actions. He reiterated that suspension is not appropriate for Dr Chupin's clinical failings as these were now many years ago and have been remediated and not repeated. He submitted that there is no evidence that Dr Chupin currently poses a risk of harm to patients, and he has gained considerable insight into his misconduct through supervision and reflection. He submitted that the Tribunal can therefore now be satisfied that Dr Chupin has insight and does not pose a significant risk of repetition. Mr Williamson submitted that this is not a case for which erasure is more likely to be the appropriate sanction. He maintained that the Tribunal has no reason to think that Dr Chupin should not practise again, whether for public safety reasons or to protect the reputation of the profession.

250. With regard to Dr Chupin's personal circumstances, Mr Williamson submitted that Dr Chupin has XXX, he is the main breadwinner so a period of suspension will be punitive for him, including financially. Mr Williamson accordingly submitted that anything more than a short period of suspension, of one month, would not be in the best interests of his patients or colleagues.

The Tribunal's Determination on Sanction

251. The decision as to the appropriate sanction, if any, to impose is a matter for the Tribunal exercising its own judgement. In reaching its decision, the Tribunal has taken The Sanctions Guidance (2024) ('SG') into account and has borne in mind the overarching objective.

252. The Tribunal reminded itself that the main reason for imposing any sanction is not to punish or discipline doctors, even though the sanction may have a punitive effect. Throughout its deliberations, the Tribunal applied the principle of proportionality, balancing Dr Chupin's interests with the public interest. Furthermore, the Tribunal bore in mind the overarching objective, namely to protect, promote and maintain the health, safety and wellbeing of the public; to promote and maintain public confidence in the profession; and to promote and maintain proper professional standards and conduct for members of the profession. The Tribunal bore in mind that the interests of the medical profession as a whole were more important than that of an individual doctor.

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

Aggravating Factors

254. The Tribunal noted Ms Barbour's submission that Dr Chupin has not shown timely insight into the issue of dishonesty. However, the Tribunal took into account Dr Chupin's denial of a number of allegations of dishonesty (most of which the Tribunal found not proved) and acknowledged that this made the timely development of insight since the decision on Facts was handed down in August 2024 more difficult. In light of this, the Tribunal placed less weight on the timeliness of the insight.

255. The Tribunal does acknowledge, however, that dishonesty is, in itself, an aggravating factor, although Dr Chupin's dishonesty related to his professional role and was an isolated incident which the Tribunal has found more likely than not occurred '*in the moment'* and was not premeditated.

Mitigating Factors

256. The Tribunal found the following mitigating factors were present. Dr Chupin has no previous findings of impaired fitness to practise. At the time of events, Dr Chupin was a recently qualified GP and was only a matter of weeks into his first substantive role. Dr Chupin was facing stressful personal circumstances and XXX. There is a considerable lapse of time since the incidents occurred (some three to four years). Dr Chupin has carried out extensive remediation regarding the clinical issues, including courses, reflections, and supervision under Dr G and has used the time since the last hearing constructively by undertaking remediation regarding his dishonesty. Finally, Dr Chupin has provided a range of positive testimonials from current colleagues who have confirmed they are aware of the findings of the Tribunal at impairment.

257. The Tribunal considered the matter of Dr Chupin's insight. It noted his very recent reflective statement with which it was provided together with the CPD he has undertaken recently, as well as the evidence of CPD that he provided at previous stages of the hearing. The Tribunal noted that many of the courses were relevant to the clinical issues in the case, including record keeping and managing challenging interactions with patients. The Tribunal further took into account that Dr Chupin has been subject to interim conditions of supervision for almost four years and has abided by them with no issues raised by his clinical supervisor. In addition, the Tribunal noted that Dr Chupin has now addressed the Tribunal's concerns expressed in its determination on Impairment about his apparent failure to reflect upon the usefulness of the CPD and courses undertaken by him. His recent reflections

contain comments upon the CPD and courses undertaken in September 2024. The Tribunal therefore found that Dr Chupin had developed good insight into his clinical failings.

258. In the determination on impairment, the Tribunal indicated that it was concerned that Dr Chupin had stated that he would not be prepared in the future to discuss XXX with colleagues. However, the Tribunal noted that, in his reflective statement, Dr Chupin stated the following,

> *'I also read that the Tribunal said it was concerned that I had indicated that I may not [XXX] or ask for help in the future and was not satisfied that I would ensure [XXX] if a similar situation arose again. I would like to reassure the panel and GMC, that I will be discussing [XXX] with my practice manager [Dr G], and if needs to [XXX].Now I understand my limitations, and seriousness of not providing adequate care due to [XXX].'*

259. The Tribunal took this into account and found that Dr Chupin had fully reflected on the findings of the Tribunal at the impairment stage and recognised the importance of XXX in relation to patient safety. It also noted that Dr Chupin had requested, and taken, some time off work after the last stage of the hearing XXX, which demonstrated that he was able to implement his plan XXX.

260. The Tribunal then considered Dr Chupin's insight into his dishonesty. The Tribunal noted that Dr Chupin has undertaken a number of recent relevant courses, such as ethics and probity, managing adverse incidents, and on GMP. The Tribunal also noted Dr Chupin's reflections on dishonesty,

> *'The Tribunal found dishonesty in relation to me not indicating that the amendment was retrospective. I recognise those are very significant failings by me and indicate a deliberate failure to apply fundamentals of Good Medical Practice. I take them very seriously and have made every effort to improve my practice, and to make sure that the likelihood of me repeating anything similar is zero in future. I take full responsibility for my actions, it was unacceptable for me to make those changes in the record, and not to indicate that they were retrospective. I want to make clear that I take it very seriously, I recognise that it was wrong, and fully recognise how serious this is.*

The Tribunal findings of dishonesty make clear the impact of a single incident of dishonesty and it being a matter serious enough to impact my fitness to practise and the public interest and public protection. I have now had more opportunity to reflect on those aspects of the findings.'

261. The Tribunal found that Dr Chupin has shown an appreciation of what went wrong, why it went wrong, and the effect it could have upon public trust in the profession. The Tribunal found that Dr Chupin had addressed the factors which contributed to his misconduct, including XXX. The Tribunal noted that, although Dr Chupin did not make a direct apology in his reflective piece, he has made apologies to the patients involved in previous stages of the proceedings. Moreover, the Tribunal considers that his reflections emphasise that he has understood the effect of his dishonesty upon the public and his responsibilities in this regard.

262. Finally, the Tribunal considered the cultural differences which may arise when showing insight and reflection. The Tribunal noted that, notwithstanding that he speaks it well, English is not Dr Chupin's first language. It further noted that Dr Chupin is naturally reserved, and his background and upbringing in Belarus made it difficult for him to raise XXX matters with colleagues. The Tribunal took this into account when evaluating the evidence of reflection and insight provided by Dr Chupin. It found that this may have resulted in his reflective statement not being as clear and concise an expression of insight as might be expected in other cases, and which was likely to have accounted for some small inconsistencies between his reflections and his earlier evidence regarding the incident of dishonesty.

263. In conclusion, the Tribunal found that Dr Chupin has a good understanding, as a result of the salutary effect of these proceedings and his own reflective work, of what he needs to do in the future to ensure that the incident of dishonesty does not happen again. The Tribunal concluded that, although his reflections have been provided late in proceedings, Dr Chupin has shown sufficient insight to satisfy the Tribunal that the misconduct is unlikely to be repeated. The Tribunal therefore found that Dr Chupin's insight into his dishonesty was a mitigating factor.

264. Before going on to consider what sanction is appropriate, the Tribunal pauses there to note Mr Williamson's submission that, as Dr Chupin has now fully remediated the clinical concerns about his practice, a sanction (especially one of suspension) is not appropriate for Dr Chupin's past deficient performance. Mr Williamson maintained that the clinical failings

were many years ago, have been remediated and have not been repeated. There was no evidence that Dr Chupin currently poses a risk of harm to patients. He has gained insight into the clinical deficiencies and has remediated them, having been prepared to undergo considerable learning and supervision and reflection. The Tribunal also noted that Dr Chupin has now addressed the Tribunal's concerns about sharing XXX with colleagues and about reflecting on CPD and courses undertaken, so it agrees with this submission and confirms that it is now satisfied that Dr Chupin, having fully remediated his misconduct in this regard, is effectively no longer impaired in relation to those clinical issues. The Tribunal therefore has considered the question of sanction only with regard to the issue of dishonesty.

No action

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

266. The Tribunal determined that, in view of the serious nature of its findings on the facts and on impairment, it would be neither sufficient, proportionate nor in the public interest to conclude this case by taking no action. The Tribunal determined that there were no exceptional circumstances and therefore there could be no justification to conclude the case by taking no action.

Conditions

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

268. The Tribunal bore in mind that Dr Chupin has been subject to interim conditions, and has complied with those conditions, so it is likely that he would comply with any conditions it may impose. However, the Tribunal considered that conditions would not be appropriate to address the finding of dishonesty. It considered that it would be difficult, if not impossible, to formulate conditions of practice which would address this issue. Moreover, the Tribunal considered that conditions would not be sufficient to maintain public confidence in the profession and uphold proper professional standards. The Tribunal was therefore satisfied that the imposition of conditions would not be an appropriate or proportionate response.

Suspension

269. The Tribunal considered the relevance of the following paragraphs of the SG:

*‘**91** Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.*

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

***93** Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions (see paragraphs 24–49).’*

270. The Tribunal was mindful that any dishonesty is serious and is behaviour not befitting of a registered doctor. The Tribunal further bore in mind that a period of suspension would temporarily prevent Dr Chupin from practising and therefore would have a punitive effect, particularly impacting upon him financially.

271. However, the Tribunal found that the misconduct in this case is so serious that a suspension is the least restrictive sanction required to protect members of the public, maintain public confidence in the profession and uphold proper professional standards. The Tribunal found that it is inevitable that dishonesty will have an adverse effect on the reputation of the medical profession because, as set out in GMP, the public must be able to place their trust in doctors.

272. The Tribunal reminds itself that it has found that Dr Chupin’s dishonesty was a single, isolated incident which was at the lower end of the spectrum of dishonesty and occurred in stressful circumstances for Dr Chupin. The Tribunal found that Dr Chupin has shown insight into his misconduct and has considered at length the factors which led to his dishonest alteration of Patient B’s records. The Tribunal was satisfied that there is sufficient evidence

that Dr Chupin has taken steps to mitigate his actions and prevent repetition of the misconduct.

273. The Tribunal then went on to consider the factors which may indicate that suspension is the appropriate sanction. The Tribunal found that the following paragraphs are relevant in this case:

> *'**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.*
> > *...*
> > ***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.'*

274. The Tribunal found, as set out above, that any sanction lower than a suspension would not be sufficient to protect the public, given the serious nature of the misconduct.

275. The Tribunal further noted that a period of four years has passed since the incident and there is no evidence that the misconduct has been repeated.

276. Finally the Tribunal was satisfied, as set out above, that Dr Chupin has now demonstrated sufficient insight into his actions. He has acknowledged the need to be open and honest with his employer about XXX and take time off when necessary. He has undertaken relevant CPD and provided reflections which show his understanding of the impact of his actions, not only on himself and those involved, but on the profession as a whole. Finally, the Tribunal found that these proceedings have been a salutary lesson to Dr Chupin which he will not forget. The Tribunal was satisfied, therefore, that he does not pose a significant risk of repeating the behaviour.

Erasure

277. Before determining that a suspension is the appropriate sanction, the Tribunal considered the sanction of erasure.

278. The Tribunal found the following paragraphs of the SG to be relevant to its considerations:

> *'108 Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.*
>
> *109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).*
>
> > *a A particularly serious departure from the principles set out in Good medical practice where the behaviour is difficult to remediate.*
> > *b A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.*
> > *…*
> > *h Dishonesty, especially where persistent and/or covered up (see guidance below at paragraphs 120–128). '*

279. The Tribunal found that, while there are factors present in this case that may indicate that erasure is the appropriate sanction, it is not the only means of protecting the public. The Tribunal bore in mind that Dr Chupin's dishonesty was an isolated incident which occurred in a stressful situation for Dr Chupin. The Tribunal has therefore found that the misconduct was not fundamentally incompatible with continued registration and erasure would be a disproportionate sanction.

Sanction determination

280. The Tribunal therefore determined that a period of suspension is the appropriate and proportionate sanction in this case and one which satisfies the overarching objective set out above. Further, although it is not bound by them, the Tribunal notes that this conclusion is in line with the submissions of both parties.

Length of suspension

281. When considering the length of suspension, the Tribunal agrees that a short period of suspension would be adequate to mark the seriousness of the misconduct. It took into

account that the dishonesty was a single isolated incident which was low on the spectrum of dishonesty, and Dr Chupin has shown extensive reflection and remediation and has developed sufficient insight. Furthermore, the Tribunal has found that there is a low risk of repetition.

282. The Tribunal noted Mr Williamson's submission that a suspension for a period of one month would be sufficient in the circumstances of this case. However, the Tribunal considers that imposing what is effectively the minimum period of suspension would be insufficient to mark the seriousness of the misconduct in this case, namely dishonesty. Having said that, and taking particular account of the mitigating factors set out above, the Tribunal found that a slightly longer suspension of two months was the more proportionate and appropriate sanction.

Review hearing

283. The Tribunal determined not to direct a review of Dr Chupin's case. The Tribunal was satisfied that Dr Chupin had shown sufficient insight into his dishonesty and has, essentially, remediated his misconduct in this regard, such that the risk of repetition is very low. The Tribunal considered that Dr Chupin did not have to do any more to remediate his misconduct and therefore was not required to demonstrate or develop any further insight or remediation.

Determination on Immediate Order - 29/10/2024

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

Submissions

285. On behalf of the GMC, Ms Barbour submitted that, given the findings of the Tribunal in the sanction determination, no immediate order of suspension was sought by the GMC.

286. On behalf of Dr Chupin, Mr Williamson submitted that an immediate order was not necessary.

The Tribunal's Determination

287. The Tribunal has taken into account the relevant paragraph of the SG which states:

*'**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…'*

288. The Tribunal carefully considered the above paragraph of the SG and its previous findings that there are no concerns about Dr Chupin's clinical competence or patient safety in this case. The Tribunal therefore concluded that an immediate order was not necessary to protect members of the public.

289. This means that Dr Chupin's registration will be suspended 28 days from the date on which written notification of this decision is deemed to have been served, unless he lodges an appeal. If Dr Chupin does lodge an appeal he will remain free to practise unrestricted until the outcome of any appeal is known.

290. The current interim order is hereby revoked.

291. That concludes the case.

ANNEX A – 30/11/2023
Rule 29 Application

292. On 28 November 2023 (Day 2 of the hearing), Mr Oliver Williamson, Counsel for Dr Chupin, confirmed his intention to make an application to adjourn the proceedings under Rule 29 (2) of the General Medical Council ('GMC') (Fitness to Practise) Rules 2004, as amended ('the Rules').

Background

293. On 27 November 2023 (Day 1 of the hearing) during a chance conversation, Mr Chupin informed the paralegal of his defence team that in August 2020 he travelled to his home country of Belarus XXX

294. XXX. His defence team expressed an intention to explore this issue as it could be an explanation for Dr Chupin's alleged misconduct which has brought him before the MPTS. Accordingly, Mr Williamson proceeded to make an application to adjourn proceedings for XXX.

Evidence

295. Dr Chupin relied on four documents to support his application:

- XXX
- XXX
- XXX
- XXX

Submissions

296. Mr Williamson submitted that the application was to adjourn the hearing to obtain XXX. He referred the Tribunal to the articles XXX. XXX. Dr Chupin left XXX the following day to return to his home town and thence to the UK.

297. Mr Williamson submitted that they wished to apply for an adjournment in order to obtain expert evidence XXX. The Tribunal was to note, for instance, that the events XXX predated the incident in relation to Patient A by just over two months.

298. He submitted that Dr Chupin's position has always been that, he has not acted dishonestly. He has insisted that he was, at the material times, XXX.

299. He referred the Tribunal to the Rule 7 response letter on behalf of Doctor Chupin,

dated 9 March 2022, wherein the doctor accepted his failings and gave consideration as to why his performance was deficient. XXX.

300. Mr Williamson then referred the Tribunal to the witness statement of Dr E, who conducted the NHS England investigation. He submitted that on the 9 June 2022 she met Dr Chupin for the first and only time. She made it clear that Dr Chupin co-operated fully and was very open. Mr Williamson submitted that there was nothing then to suggest that XXX was an issue within the NHS England report.

301. XXX

302. With regards to the Rule 7 response letter in relation to Patient A of 18 August 2022, Mr Williamson submitted that references were made there to XXX, as the GMC referenced properly in their opening.

303. XXX

304. With regards to the Rule 7 letter regarding Patient B, he submitted that there was reference to Dr Chupin being shocked and extremely upset by the knowledge of Patient B's death and he made it clear in that letter that he considered his standard of care was poor, but again strenuously denied dishonesty. XXX

305. Mr Williamson submitted that the experts agreed that, during the telephone conversations regarding Patient B, Dr Chupin did not sound entirely XXX, and that he was suffering XXX, which are now relevant.

306. He submitted that they are now seeking evidence about XXX which has developed from a chance conversation with Dr Chupin, where his defence team learned of his experience XXX a few months before the first consultation, with Patient A.

307. He submitted that the proceedings are plainly stressful, but must be resolved fairly and properly. He submitted that Dr Chupin would suffer significant prejudice if he were denied the opportunity to obtain further evidence in these circumstances as they now arise. He submitted that there was no alternative but to adjourn the hearing in order to obtain XXX.

308. Ms Barbour submitted that the GMC took a neutral stance on the application. However, the GMC was disappointed and frustrated. She submitted that an expert should have been instructed in the first instance to provide an opinion soon after the defence team

was informed of XXX. Furthermore, she said that whilst this issue may not have been uncovered, it might have been, if an expert was instructed. She further submitted that the expert would have been available during this trial window to provide an opinion on the new issue once it had arisen.

309. XXX

310. Having said that, Ms Barbour submitted that it is appropriate for evidence to be sought on XXX, and that the Tribunal would need that evidence in order to determine one of the central issues of the case.

311. She submitted that the GMC wished to reserve their position on wasted costs which may arise out of this adjournment.

The Tribunal's Decision

312. The Tribunal had regard to Rule 29(2) of the Rules:

> *'Where a hearing of which notice has been served on the practitioner in accordance with these Rules has commenced, the Committee or Tribunal considering the matter may, at any stage in their proceedings, whether of their own motion or upon the application of a party to the proceedings, adjourn the hearing until such time and date as they think fit'*

313. The Tribunal also accepted the advice of the LQC, who referred it to the provisions regarding adjournments set out in the case of *CPS v Picton (2006) EWHC 1108*.

314. The Tribunal carefully considered each piece of evidence relied upon by counsel for Dr Chupin in support of this application, both individually and in the round. XXX

315. The Tribunal further accepted that it was possible and arguable that XXX, could have been a factor in explaining his actions regarding Patients A and B, particularly in relation to his alleged dishonesty, in respect of which Dr Chupin had already put forward what could amount to "*innocent explanations*" for acting as he did. On that basis, the Tribunal was satisfied that there was a good reason for Dr Chupin seeking an adjournment in order to obtain further XXX evidence on this issue. Whilst the information in support of the application did arise at the last minute, the Tribunal noted that it appears to have arisen unexpectedly and by chance, which is in line with what the Tribunal understands XXX.

316. The Tribunal then considered whether any prejudice arose to either party if the hearing was adjourned. It noted that, as most of the factual allegations had been admitted, no GMC witness as to fact would have their evidence prejudiced by the inevitable delay caused by the adjournment; indeed, the only prejudice would likely be to Dr Chupin whose memory as to what was in his mind at the relevant times in October 2020 and July 2021 might be adversely affected by the further delay. The Tribunal noted that the two expert witnesses (Dr H and Dr I) were scheduled to give their evidence this week; however, their evidence was largely agreed and therefore the Tribunal concluded that they would not be unduly inconvenienced by having to return on another day some months hence. Consequently, the Tribunal concluded that there would be no significant adverse impact upon the GMC's case if the hearing to be adjourned. Having said that, the Tribunal shares the GMC's frustration and disappointment that this issue was not identified sooner, although XXX. Finally, the Tribunal notes that the application was not opposed by the GMC.

317. In the light of the information that has been provided, the Tribunal therefore determined that it would be impossible to justly consider Dr Chupin's misconduct, without the ability to consider what impact, if any, XXX had in relation to his alleged misconduct.

318. The Tribunal was of the view that proceeding today without further exploration of the evidence with regard to XXX would risk unfairness to Dr Chupin. The Tribunal has determined that an adjournment is necessary and fair and was in the interests of justice.

319. In these circumstances the Tribunal has determined to adjourn this hearing under Rule 29(2). The Tribunal considered the purpose of any adjournment and has determined that an adjournment to enable Dr Chupin to obtain further evidence about XXX is appropriate in all the circumstances of this case, in order properly to determine the issues in this case.

320. The Tribunal did consider whether anything could be salvaged in the time left available to it by hearing the expert evidence currently scheduled to be given, before finally adjourning the hearing, so as to avoid further unnecessary inconvenience to Dr H and Dr I. However, it agreed with the parties that this would not be appropriate as their opinion evidence might have to be amended if further evidence about XXX emerged.

321. The Tribunal also agreed with the parties that, having decided that the case would have to be adjourned in any event, it would nonetheless reconvene at 12.00 noon on Friday 1 December 2023 to give the parties an opportunity to make further enquiries so as to

ascertain how long Dr Chupin would need to obtain such XXX evidence and for the GMC to assimilate it and respond. Such information would be needed by the Tribunal when fixing the resumed hearing dates and when making any directions regarding the exchange of evidence prior to that hearing.

ANNEX B – 13/08/2024

Consideration of adjournment

322. The Tribunal has handed down its determination on impairment. Given the lateness of the hour, the Tribunal raised the question of adjourning the hearing part heard at this stage.

323. The Tribunal had regard to the current circumstances in this case and had regard to its powers under Rule 29(2) of the Rules:

> *'Where a hearing of which notice has been served on the practitioner in accordance with these Rules has commenced, the Committee or Tribunal considering the matter may, at any stage in their proceedings, whether of their own motion or upon the application of a party to the proceedings, adjourn the hearing until such time and date as they think fit.'*

324. The Tribunal determined that it did not have sufficient time to conclude the hearing in the time remaining today. As such, it determined to adjourn this hearing part heard.

325. The first date which this Tribunal can reconvene is 28 October 2024. It canvassed the availability of all parties that were present, who confirmed that they were available on this date.

326. When the Tribunal reconvenes, it will hear submissions on sanction.

327. The hearing is adjourned part heard until 28 October 2024, with a listing of two days. The hearing will be virtual.

328. The Tribunal hereby directs that any evidence upon which the parties wish to rely must be lodged no later than two weeks before 28 October 2024 and that written submissions be prepared and lodged by both parties no later than 25 October 2024.

ANNEX C – 13/08/2024

Addendum to Facts determination

1. Having read and heard the Stage 2 submissions of both parties, and having reconsidered the Facts determination, the Tribunal has identified an error in the latter which it considers should be amended.

2. The Tribunal refers to paragraph 12 of Ms Barbour's written note on Stage 2, which states:

> "*The allegation at 9(c)(ii) has been found proved, and further the Tribunal found that Dr Chupin's failure to record that he was making a retrospective entry/amendment to the record was dishonest, by virtue of his knowledge that the record keeping of his consultation with Patient B and Mr C would be subject to scrutiny and was also dishonest by virtue of Dr Chupin not noting that he had made a retrospective amendment to the record, thus potentially obscuring the true content of the record*."
> (The Tribunal's emphasis)

3. The Tribunal wishes to clarify that the only dishonesty that it found proved was that Dr Chupin failed to record that his amendment to Patient B's consultation note was retrospective. It did not find proved that adding the additional detail (paragraph 9b) knowing that his record keeping of the consultation would be subject to scrutiny (paragraph 10b) was dishonest, either inherently, or specifically because of that knowledge – paragraphs 138 to 145 of the Facts determination make that clear. That finding was not altered, nor was it intended to be altered, by the separate Tribunal finding that failing to record that his amendment to Patient B's consultation note was retrospective, was dishonest.

4. The Tribunal considers that this error has arisen due to the somewhat cumbersome exercise it was required to carry out when considering paragraph 11 of the allegation. It was required to consider eight possible scenarios (for example, was 9a dishonest by reason of any or all of 10b or 10c and so on?) The only explanation that the Tribunal can offer is that it probably confused itself at the end of that exercise when applying paragraph 10b to paragraph 9cii. That required it to consider that Dr Chupin's actions at paragraph 9cii (failing to record that he was making a retrospective amendment) was dishonest "by reason of" paragraph 10 b (knowing that the record of his consultation would be subject to scrutiny).

The Tribunal considered that failing to record that the entry was retrospective was dishonest per se (as indicated by paragraph 10c) and did not also become dishonest just because Dr Chupin knew that the record would be subject to scrutiny (which knowledge the Tribunal had already found not to be dishonest).

5. Accordingly, the determination on Facts should be amended as follows. Paragraphs 162 and 163 currently read:

> "*329. Accordingly, it follows that in any event the GMC has demonstrated on balance that Dr Chupin's actions at 9cii were dishonest by virtue of paragraphs 10b and 10c.*
>
> *330. Accordingly, paragraph 11 is proved in respect of paragraph 9cii as it relates to both paragraphs 10b and 10c*".

6. They should now read:

> "*162. Accordingly, it follows that in any event the GMC has demonstrated on balance that Dr Chupin's actions at 9cii were dishonest by virtue of paragraph 10c.*
>
> *163. in respect of whether Dr Chupin's actions at 9cii were dishonest by virtue of paragraph 10b, as it has found that Dr Chupin had no dishonest motive in relation to paragraph 10b, it follows that failing to record that that he was making a retrospective entry is not dishonest "by virtue of" Dr Chupin's knowledge that his record keeping would be scrutinised – it is dishonest solely due to paragraph 10c. It therefore follows that the GMC has failed to demonstrate on balance that Dr Chupin's actions at 9cii were dishonest by virtue of paragraph 10b.*
>
> *331. Accordingly, paragraph 11 is not proved in respect of paragraph 9cii as it relates to paragraph 10b but is proved in respect of paragraph 9cii as it relates to paragraph 10c*".

7. Paragraph 11 of the newly-numbered paragraph 165 should now read as follows:

> "*11. Your actions as set out at paragraph 9 were dishonest by reason of paragraph 10.*
> ***Determined and found proved in respect of paragraph 9b as it relates to paragraph 10c, and paragraph 9cii as it relates to paragraph 10c.***"

SCHEDULE 1

History	still drinking alcohol daily, no vomiting, no sob, no chest pain, no recent falls, asked for stronger painkillers,
Comment	agreed to tramadol nefopam advised to call us back if no improvement patient is happy with the plan

SCHEDULE 2

History	still drinking alcohol daily, **slurred speech on the phone**, no vomiting, no sob, no chest pain, no recent falls, asked for stronger painkillers **due to ongoing pain**, **passed the phone to her son, who informed that the patient is in pain, and current painkillers are not helping, informed about the recent blood results, agreed to try tramadol for 1-2 days, if no response to call back**
Comment	agreed to tramadol nefopam advised to call us back if no improvement patient is happy with the plan