

PUBLIC RECORD

Dates: 01/06/2026 - 08/06/2026

Doctor: Dr Neel CHAUHAN

GMC reference number: 6167992

Primary medical qualification: BM BS 2008 The University of Brighton and the University of Sussex

Type of case	Outcome on facts	Outcome on impairment
Misconduct	Facts found proved	Impaired

Summary of outcome
Suspension, 4 months

Tribunal:

Legally Qualified Chair	Mrs Cathie Seville
Lay Tribunal Member:	Mr Mark O'Brien
Registrant Tribunal Member:	Dr Julian Williams
Tribunal Clerk:	Ms Hinna Safdar

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Lee Gledhill, Counsel, self-directed
GMC Representative:	Mr Adam Lodge, Counsel

Attendance of Press / Public

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

Protecting the Public

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

Determination on Facts and Impairment - 04/06/2026

1. Dr Chauhan qualified in 2008 from The University of Brighton and the University of Sussex. Prior to the events which are the subject of the hearing, Dr Chauhan was working as a General Practitioner ('GP').
2. The allegations that have led to Dr Chauhan's hearing relate to his conduct. It is alleged that on one or more dates between March and July 2023, Dr Chauhan undertook telemedicine work for both BrisDoc Healthcare Services ('BrisDoc') and Doctor Care Anywhere ('DCA') at the same time and claimed payment from both. It is alleged that Dr Chauhan's actions were dishonest.
3. The initial concerns were raised with the GMC by National Health Service England Performance Advisory Group ('NHSE PAG') following an internal investigation meeting on 13 March 2024.

The Allegation and the Doctor's Response

4. The Allegation made against Dr Chauhan is as follows:

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

1. On or around one or more of the dates set out in Schedule 1, you:

- a. undertook work for both BrisDoc Healthcare Services ('Brisdoc') and Doctor Care Anywhere ('DCA') at the same time (the 'Simultaneous Work'); **Admitted and found proved**
 - b. claimed payment from both Brisdoc and DCA for the Simultaneous Work. **Admitted and found proved**
2. You knew that you should not have:
- a. undertaken Simultaneous Work for both Brisdoc and DCA; **Admitted and found proved**
 - b. claimed payment from both Brisdoc and DCA for the Simultaneous Work. **Admitted and found proved**
3. Your actions as set out at paragraph 1 were dishonest by reason of paragraph 2. **Admitted and found proved**

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

The Admitted Facts

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

6. On Day 2 of the proceedings, through his Counsel in submissions on misconduct and impairment, Dr Chauhan accepted that the admitted facts found proved would amount to serious misconduct.

Impairment

7. 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 above, Dr Chauhan's fitness to practise is impaired by reason of misconduct.

Evidence

Witness evidence

8. The GMC did not call any witnesses to give oral evidence, as their evidence was unchallenged by Dr Chauhan however, it provided witness statements from the following witnesses:

- Dr A, the Deputy Chief Medical Officer and Responsible Officer at DCA, dated 15 December 2024.
- Mr B, the Head of People Operations at DCA, dated 13 January 2026.
- Ms E, the Medical Director for BrisDoc, dated 25 November 2024. She also provided a supplemental witness statement dated, 12 December 2025.
- Ms F, the Deputy Medical Director at BrisDoc, dated 14 January 2026.
- Ms G, a Governance Manager at BrisDoc, dated 27 December 2024. She also provided a supplemental witness statement dated, 18 December 2025.
- Mr H, a Clinical Adviser for NHS England, dated 26 December 2025.

9. Dr Chauhan provided his own witness statement dated 17 February 2026, and he gave oral evidence at the hearing.

10. In addition, the Tribunal received Testimonial and evidence of remediation and insight from the following witnesses on Dr Chauhan's behalf:

- Dr I, via video link.
- Dr J, via video link.

Documentary Evidence

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

- Dr Chauhan Invoice, incorrectly sent to DCA, dated 31 July 2023
- Email from Mr B (DCA) to BrisDoc, dated 11 August 2023
- DCA correspondence with Dr Chauhan re. BrisDoc invoice, dated 4 August 2023 to 7 August 2023
- Dr Chauhan DCA invoices, dated 31 January 2023 to 31 August 2023
- Dr Chauhan DCA rotas, dated 1 January 2023 to 25 August 2023
- DCA Terms of Engagement (signed), dated 23 November 2016
- Dr Chauhan DCA e-modules, dated 20 February 2019 to 31 May 2023
- Email from Ms K (DCA GP Lead), dated 11 August 2023
- Meeting Notes, DCA and Dr Chauhan, dated 25 August 2023

- DCA Termination Letter, dated 3 October 2023
- BrisDoc Terms of Engagement, dated August 2020
- Email from Ms F to NHS England, dated 7 September 2023
- BrisDoc Terms and Conditions (signed), dated 20 April 2014
- BrisDoc Terms of Engagement (signed), dated 11 September 2020
- BrisDoc Standard Operating Procedure for Self-Employed GPs, dated 1 September 2019
- BrisDoc Performance Advisory Group (PAG), dated 22 November 2023
- Emails with BrisDoc Rota Team, dated 14 August 2023
- Internal BrisDoc email re. call with Dr Chauhan, dated 31 August 2023
- Email to Dr Chauhan following call, dated 26 June 2023
- Email from Dr Chauhan, dated 7 September 2023
- Email to NHS England re. call with Dr Chauhan, dated 7 September 2023
- Emails with Dr Chauhan, dated 27 September 2023 to 29 September 2023
- Email to Dr Chauhan following call, dated 18 October 2023
- Spreadsheets of overlapping shifts, dated 3 March 2023 to 30 September 2023
- Dr Chauhan’s BrisDoc invoices, dated 1 March 2023 to 30 August 2023
- BrisDoc Performance Advisory Group (PAG), dated 23 November 2023
- Interview with Dr Chauhan, dated 13 March 2024
- Investigation Report, dated July 2024
- Dr Chauhan’s Admissions, dated 17 February 2026
- Invoice from the Law Office of Ms C, dated 30 December 2025
- Completed CPD Log, dated 15 February 2026
- Verified CPD Study Plan, undated
- Reflective pieces, undated
- Professional values discussion, dated 6 March 2026
- Remediation report of Dr D, Remediation Consultant, dated 4 April 2026
- Apology Letter (BrisDoc), undated
- Apology Letter (DCA), undated

Submissions

On behalf of the GMC

12. Mr Adam Lodge, Counsel, submitted that Dr Chauhan’s behaviour, now admitted, amounted to serious misconduct and should properly result in a finding of impairment. While there is no statutory definition of impairment, he reminded the Tribunal of the overarching objective and the guidance derived from Dame Janet Smith in the Fifth Shipman Report, as

adopted in *NMC v Grant*. Mr Lodge emphasised the four well-established considerations: whether the doctor had put patients at unwarranted risk of harm; brought the profession into disrepute; breached fundamental tenets of the profession; or acted dishonestly. He suggested that the latter three factors were clearly engaged.

13. Turning to the new MPTS guidance introduced in November 2025 ('the Guidance'), Mr Lodge directed the Tribunal to the staged approach required when assessing impairment. The first step was to determine whether there was a legal basis for considering impairment, which in this case arose from serious misconduct representing a serious departure from Good Medical Practice (2013) ('GMP'). He submitted that paragraphs 65, 73 and 77 of the guidance were relevant, particularly the requirement that doctors cooperate with formal inquiries and act openly and honestly. The seriousness of the misconduct was accepted, and this amounted to the legal basis for impairment being established.

14. Mr Lodge submitted that there was a risk of current and ongoing risk to public protection, noting that public protection encompasses safeguarding patient safety, maintaining public confidence, and upholding proper professional standards. In this case, he suggested that all limbs of public protection were engaged. He submitted that the starting point for assessing risk depended on the seriousness of the allegations, which involved Dr Chauhan simultaneously working for and receiving payment from two clinical service providers, conduct accepted as dishonest. Although no actual patient harm occurred, Mr Lodge submitted that the behaviour had the potential to compromise patient safety and had undoubtedly undermined public confidence and professional standards.

15. Mr Lodge submitted that dishonesty of this nature, which was work related, repeated, and financially significant, placed the case at the higher end of the seriousness spectrum. He estimated that the overlapping 89.5 hours of work generated several thousand pounds, possibly up to £8,500. He further identified aggravating features: the persistence of the behaviour over months; its premeditated nature; a reckless disregard for patient safety and professional standards; awareness of its dishonesty; attempts to conceal it; and the fact that it only ceased when discovered through the doctor's own invoicing error.

16. Mr Lodge acknowledged the personal difficulties described by Dr Chauhan but emphasised that contextual mitigation carries less weight in cases at the higher end of seriousness. Similarly, while accepting that the doctor had demonstrated insight and undertaken remediation, he noted that these efforts began relatively late and would also carry limited weight given the seriousness of the misconduct.

17. Mr Lodge submitted that the allegations engaged all three limbs of public protection and that Dr Chauhan posed a high current and ongoing risk. Accordingly, a finding of impairment was necessary to maintain public confidence and uphold professional standards.

On behalf of Dr Chauhan

18. Mr Gledhill submitted that Dr Chauhan accepted that he had fallen below the standards required of a doctor and had committed serious professional misconduct. However, Mr Gledhill invited the Tribunal to consider the passage of time, the work undertaken since the events, his previous good character, and the absence of any repetition. He argued that the doctor had made “significant changes to his own psychology such that it’s unlikely that this would ever happen again,” emphasising that the risk of repetition was negligible.

19. Mr Gledhill reminded the Tribunal that Dr Chauhan had accepted the facts from the outset, made full admissions, and acknowledged that his dishonest conduct and overlapping shifts had fallen well below professional standards. Dr Chauhan told the Tribunal in his oral evidence that he recognised that his behaviour would damage trust in the profession, but he had taken steps to learn from his misconduct and to ensure that it would not recur. Mr Gledhill submitted that Dr Chauhan had reflected deeply on the circumstances, recognising that attempting to manage serious personal problems alone had contributed to his actions. He added that Dr Chauhan did not advance these matters as an excuse, but they provided context: he had been overwhelmed by XXX, and significant financial pressures arising from XXX.

20. Mr Gledhill submitted that although there had been some impact on patient waiting times, there was no evidence of actual patient harm. He added that Dr Chauhan now valued a strong support network and had committed to openness rather than isolation. The evidence of Dr I and Dr J, both longstanding colleagues, was said to be of high quality. They had been surprised by his conduct but had worked closely with him, providing challenge and support. Their evidence demonstrated a “deep exploration of the causes” of his behaviour and showed that they believed he had fully understood his failings and learned from them.

21. Turning to remediation, Mr Gledhill highlighted the structured programme undertaken by the doctor, including reflective work, discussions with colleagues, and extensive reading. He referred to the CPD log, noting entries such as the reflection that “*my failure to disclose overlapping employment... was a direct contravention of these standards.*” He submitted that this demonstrated Dr Chauhan’s active engagement with probity and

professional values. He submitted that the GMC's reliance on the guidance was understandable, but that the Tribunal should also consider the insight gained and Dr Chauhan's development since the misconduct. Mr Gledhill emphasised that not all misconduct requires a finding of impairment and invited the Tribunal to consider a warning if appropriate. He noted that Dr Chauhan, now living in Hawaii, had given credible and insightful evidence despite the time difference, he had learned the importance of honesty and integrity, had implemented safeguards, and had developed strategies to manage stress and financial pressures. Mr Gledhill submitted that Dr Chauhan accepted that fear did not excuse his conduct and had explained how he would act differently in future.

22. Mr Gledhill submitted that the risk of repetition was extremely low, that Dr Chauhan's insight and remorse were genuine, and that the supportive evidence of his colleagues demonstrated meaningful change. Drawing these matters together, he submitted that Dr Chauhan's fitness to practise was not currently impaired.

The relevant legal principles

23. Throughout its deliberations, the Tribunal must bear in mind the statutory overarching objective as set out in section 1 Medical Act 1983. It also must have regard to the Guidance.

24. The Tribunal is reminded 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.

25. The Tribunal must first be satisfied that the case engages one or more of the statutory grounds under Section 35C of the Medical Act 1983.

26. In approaching the decision about misconduct, the Tribunal should be 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.

27. The Tribunal bore in mind that misconduct has been defined in the case of *Roylance v GMC (No.2)* [2000] 1 AC 311 as '*a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.*' In that case, the Privy Council went on to say that '*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.'

28. The Tribunal was mindful that to amount to misconduct, the behaviour will be a serious departure from the professional standards, as set out in GMP. The Tribunal should ask itself how far short of those standards the doctor's conduct has fallen.

29. The Tribunal was reminded it must determine whether Dr Chauhan's fitness to practise is impaired today, it must consider the judgement of Mr Justice Silber in *Cohen v GMC [2008] EWHC 581 (Admin)* and take into account whether the matters are remediable, have been remedied and any likelihood of repetition. But, it should be mindful that there are some cases of such seriousness that a finding of impairment may be appropriate even if the misconduct has been remedied and is unlikely to be repeated, such cases may include those of dishonesty.

30. The Tribunal is reminded whilst there is no statutory definition of impairment, however, the test set out by Dame Janet Smith in the Fifth Shipman Report, cited in *CHRE v NMC and Grant [2011] EWHC 927 (Admin)* indicates that the Tribunal should consider the following questions to assist in determining whether or not the doctor's fitness to practise is impaired:

- a) *Whether the registrant 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;*
- b) *Whether the registrant has in the past brought and/or is liable in the future to bring the profession into disrepute;*
- c) *Whether the registrant has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession.*
- d) *Whether the registrant has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

31. The Tribunal should consider if a finding of impairment is required in order to satisfy one or more of the three limbs of public protection.

32. The Tribunal was reminded that the three parts of public protection are to protect, promote and maintain the health, safety and well-being of the public, to promote and

maintain public confidence in the profession, and to promote and maintain proper professional standards and conduct for members of the profession.

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

- where on the spectrum of seriousness the allegation lies, based on the facts found proved,
- the impact of any specific features which may increase the level of seriousness,
- the impact of any relevant context known about Dr Chauhan and/or his working environment,
- how Dr Chauhan has responded to the Allegation, and
- whether Dr Chauhan has kept his knowledge and skills up to date.

34. If the Tribunal reaches a view that Dr Chauhan poses a current and ongoing risk to public protection that requires restrictive action in response, it should make a finding that his fitness to practice is impaired.

The Tribunal's determination on impairment

Misconduct

35. The Tribunal considered whether the facts found proved amount to misconduct and, if so, whether that misconduct is serious.

36. In determining whether Dr Chauhan's actions amounted to serious misconduct, the Tribunal considered that Dr Chauhan admits his behaviour amounted to misconduct that was serious.

37. The Tribunal had regard to the definition of misconduct as set out in the case of *Roylance*, namely that misconduct is a serious departure from the standards expected of a registered medical practitioner.

38. The Tribunal referred to GMP 2013 and considered that the following paragraphs 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.

36 You must treat colleagues fairly and with respect.

37 You must be aware of how your behaviour may influence others within and outside the team

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

73 You must cooperate with formal inquiries and complaints procedures and must offer all relevant information while following the guidance in Confidentiality.

77 You must be honest in financial and commercial dealings with patients, employers, insurers and other organisations or individuals.'

39. In analysing the Allegation, the Tribunal considered each paragraph separately.

Paragraph 1(a) and (b)

40. In relation to paragraphs 1(a) and 1(b) of the Allegation, The Tribunal found that Dr Chauhan had undertaken work for both BrisDoc and DCA at the same time and had claimed payment from both organisations for the same overlapping hours. This 'simultaneous work' was not accidental or incidental and involved a deliberate choice to accept and perform two roles concurrently, knowing that he could not be available to both employers simultaneously.

41. The Tribunal considered the practical consequences of the misconduct. The first was a delay in patient care. The Tribunal noted the evidence of Ms G who set out in her witness statement the reduced number of cases Dr Chauhan was able to triage whilst he was working the overlapping shifts, as opposed to when he worked solely for BrisDoc.

42. It is accepted by DCA, BrisDoc and the GMC that no patient harm was identified as a result of the overlapping shifts. However, the Tribunal considered that a practitioner undertaking two roles simultaneously could increase the risk of harm to patients.

43. The Tribunal considered the impact on Dr Chauhan’s colleagues by virtue of the overlapping shifts, this could have included but was not limited to, those colleagues being required to absorb additional clinical responsibilities in his absence and Dr Chauhan not being available to those colleagues to speak or liaise with on particular cases or clinical discussions. The impact on colleagues could have been significant.

44. The Tribunal noted the evidence of Ms E, in which she confirmed that *“Our terms of engagement at Exhibit KR/1 also do not contain a specific clause preventing doctors from working for two providers simultaneously. This is because it never occurred to us that a doctor might do this”* and the evidence of Dr A, who stated that *“DCA has no issue with doctors that work for them having two employers, however, the nature of the job as a doctor working for DCA is seeing patients virtually (either via telephone or video call) during their booked appointments for the entirety of the shift. One would hope that it did not therefore need to be explicitly explained to doctors working for DCA that they could not therefore work for two providers simultaneously during these same shift times, because DCA does not expect a doctor to see another patient when they already have an appointment booked with one patient.”*

45. It is clearly evident that both DCA and BrisDoc were unaware that Dr Chauhan was working for them both simultaneously and that they had an expectation that Dr Chauhan would work exclusively for them when booked onto a shift.

46. The Tribunal was satisfied that fellow members of the profession would find Dr Chauhan’s behaviour deplorable given the potential impact on patient care and collaborative working. The Tribunal was also satisfied that members of the public would find the actions of Dr Chauhan unacceptable given the risk to patient care.

47. The Tribunal determined that this behaviour fell significantly below the standards expected and amounted to misconduct which was serious.

Paragraph 2(a) and (b) and 3.

48. The Tribunal then turned to paragraphs 2(a) and 2(b), concluding that Dr Chauhan knew he should not have undertaken simultaneous shifts for both organisations and knew that claiming payment from each for the same period was improper. On that basis, the Tribunal determined that the conduct described at paragraph 1 was dishonest by reason of paragraph 2, satisfying paragraph 3 of the allegation.

49. Dr Chauhan gained financially by virtue of his dishonesty. The GMC submitted that Dr Chauhan had obtained approximately £8,500 as a result of the overlapping work. These monies were obtained by dishonest behaviour.

50. Honesty and integrity are fundamental tenets of the profession and Dr Chauhan breached these by his conduct.

51. The Tribunal considered that members of the medical profession would regard such behaviour as a significant departure from the professional standards expected of a doctor. The Tribunal considered that members of the public would find the behaviour unacceptable, in particular as some of the monies misappropriated were public funds, as BrisDoc was an NHS out of hours provider.

52. The evidence of the two oral witnesses, both friends of Dr Chauhan's and experienced doctors, was of being shocked and appalled that Dr Chauhan had worked two clinical roles simultaneously, and their evidence reinforced the Tribunal's assessment of the seriousness of the behaviour.

53. Drawing these matters together, the Tribunal concluded that Dr Chauhan's actions represented a significant departure from fundamental professional standards. The combination of deliberate dishonesty, financial gain and the clear breach of multiple probity-related provisions of GMP meant that the behaviour amounted to misconduct which was serious.

Is there a legal basis for considering impairment?

54. Having determined that Dr Chauhan's conduct amounts to serious professional misconduct, the Tribunal was satisfied that the ground of misconduct under s35C(2) of the Medical Act 1983 is established.

55. The Tribunal therefore determined that there is a legal basis for considering Dr Chauhan's fitness to practise by reason of misconduct.

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

Where on the spectrum of seriousness does the allegation lie?

57. The Tribunal considered the nature and seriousness of the misconduct. It noted that the misconduct involved dishonesty, and that dishonesty which is repeated, persistent, undertaken in a professional context and which led to significant financial gain ordinarily falls at the higher end of the spectrum of seriousness. The Tribunal determined that the behaviour was a serious departure from professional standards and breached fundamental tenets of the profession, including honesty and integrity.

58. The Tribunal noted that Dr Chauhan’s dishonesty was repeated and persistent, premeditated, was a reckless disregard for professional standards, undermined collaborative working, put his own interests before those of patients, and there was an attempt to hide or avoid taking responsibility for his behaviour when found out.

59. Dr Chauhan’s dishonesty was in relation to two different organisations, related to his employment and covered 38 days in a period of three months. He consciously made a decision to work simultaneous shifts for substantial financial gain, which would not have been available to him had he been honest with his two employers. He did not consider the impact of patient care and safety. He did not consider the negative impact of his behaviour on his colleagues. He accepts that at the time he knew what he was doing was wrong, but he had a blatant disregard for professional standards. When challenged via email on 7 August 2023 and in person on 25 August 2023, he lied to cover up his behaviour and indicated that there had been a clerical error.

60. The Tribunal considered that these additional features increased the seriousness of the allegation and therefore placed the misconduct at the higher end of the spectrum of seriousness.

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

61. The Tribunal did not find any professional circumstances that led to his misconduct. However, it accepted that Dr Chauhan was experiencing significant personal challenges at the time of his dishonesty. XXX. He described feeling overwhelmed and stated that *“I was scared for [XXX] and it affected my judgement,”* a sentiment the Tribunal noted when considering the risk of repetition. The Tribunal recognised that such pressures may have contributed to impaired decision-making.

62. XXX

63. A further contextual factor identified by the Tribunal was outlined in his reflective statement in which he stated that, *‘I have also reflected on how my background may have contributed to my reluctance to seek help. As a doctor of Indian heritage, I was raised with strong expectations about self reliance, providing for family, and not burdening others with personal problems.’* He explained that he had attempted to manage his difficulties alone rather than reaching out to colleagues, friends or professional support services. The Tribunal considered that this reluctance to seek assistance may have exacerbated his sense of isolation and contributed to the poor decisions that he ultimately made.

64. In evaluating these contextual elements, the Tribunal emphasised that personal, family and legal stressors, financial strain and cultural inhibitions around help-seeking provided a contextual backdrop against which to understand why Dr Chauhan made his very poor behavioural decisions. However, the context could not meaningfully reduce the seriousness of the misconduct.

How has Dr Chauhan responded to the Allegation?

65. The Tribunal carefully considered the extent of Dr Chauhan’s insight and remediation and concluded that both were substantial. It was satisfied that he had worked very hard over a sustained period to understand the seriousness of his misconduct and the professional standards he had breached. His oral and written evidence, together with the work he undertook with Dr D, demonstrated that he fully understood what he had done wrong and how he ought to have behaved. Although the GMC submitted that his insight had developed relatively late, the Tribunal accepted the evidence of Dr I that Dr Chauhan had begun reaching out for support much earlier than suggested. Dr I could not recall when Dr Chauhan had reached out but described it as, *“some distance in time ago.”*

66. The Tribunal also noted that the BrisDoc PAG report dated 22 November 2023 references Dr Chauhan making *“an unsolicited written apology and regret”* for his actions and in an email to BrisDoc dated 7 September 2023 Dr Chauhan wrote *“I deeply regret the current situation and feel a profound sense of responsibility for letting down the team at Brisdoc”*. The Tribunal considered that at the end of 2023 Dr Chauhan was beginning his journey towards insight and remediation. Although, in 2023 this journey was still very much in its infancy.

67. The Tribunal noted that Dr Chauhan's XXX was finalised in October 2025 and this appears to have been a turning point in his ability to engage meaningfully with reflective work.

68. The Tribunal viewed the work that Dr Chauhan has engaged with as exceptional. He has worked with Dr J and Dr I informally and with Dr D as a professional remediation consultant. He has provided detailed, indepth and thoughtful reflective pieces which show a deep understanding of his insight into his misconduct.

69. He has also planned into the future ongoing work with Dr J, to continue to engage with reflective work every 3 months, to maintain and improve his insight.

70. Dr Chauhan had admitted all the facts and accepts that his behaviour amounts to serious misconduct. The Tribunal regarded his insight as exceptional, observing that it could not identify anything further it would reasonably expect him to have done to demonstrate a fuller understanding of his failings. While the Tribunal acknowledged that he had not repaid the money earned from the overlapping roles, it accepted the evidence of Ms E that the sum had been written off and that Dr Chauhan had expressed genuine gratitude for this. The Tribunal also noted the reason Dr Chauhan acted dishonestly was a result of significant financial pressures, and considered that repaying BrisDoc and DCA may have added to his financial pressures. However, in all other respects, he had taken clear steps towards remediation, including offering a written apology for his misconduct in January 2026.

71. The Tribunal also considered his engagement with the regulatory process. Although he had not engaged with the GMC's investigation at the outset, he had participated fully in the investigations of BrisDoc, NHS England and in the MPTS proceedings from September 2024 onwards. When assessing the impact of his insight, the Tribunal found that the nature and quality of his reflective work was high, detailed and expansive. While the most comprehensive material was more recent, there was credible evidence of emerging insight as early as late 2023, when he was engaging with the BrisDoc investigation and when he first contacted Dr I for support.

72. In relation to remediation, the Tribunal concluded that Dr Chauhan had addressed the allegations thoroughly in the work he had undertaken. His CPD activities and reflective statements demonstrated meaningful engagement with probity, honesty and professional values. The testimonials provided further support for the depth of his insight. The Tribunal placed particular weight on the commitment of Dr J, who had signed an agreement to

monitor Dr Chauhan quarterly going forward, providing an ongoing safeguard and source of professional challenge.

73. The Tribunal considered the misconduct to be serious, and less easy to remediate, however, it could be capable of remediation. It found that Dr Chauhan had gone as far as could reasonably be expected in his circumstances. It regarded the risk of repetition as highly unlikely, noting that the relationship with Dr J and the safeguards now in place formed part of a continuing process of professional support. Overall, the Tribunal concluded that Dr Chauhan had remediated his misconduct as fully as he could and had demonstrated insight of an exceptional standard.

74. The Tribunal considered that, within the limits of not being in clinical practice, Dr Chauhan has kept up to date with his knowledge and skills. He has completed his mandatory training and additional clinical training, as evidenced through his CPD record. In oral evidence, he stated that he *“stayed on top of learning, keeping up to date with clinical guidelines and developments.”* His current role involves being aware of up-to-date guidelines in family medicine. The Tribunal did not have any evidence before it that there was concern about his knowledge and skills.

75. The Tribunal has considered all of the contextual factors in relation to Dr Chauhan’s personal stress that he was under at the time, the financial pressures and the cultural difficulties to seek support. The Tribunal determined that these factors of the case did not reduce the seriousness of the misconduct and it would remain at the higher end of the spectrum of seriousness.

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

76. The Tribunal reviewed its conclusions on the previous paragraphs.

77. The Tribunal weighed up the starting point of where dishonesty lies on the spectrum of seriousness, as well as the features which would increase the level of seriousness. The Tribunal found that the Allegation fell at the higher end of the spectrum of seriousness.

78. The Tribunal had regard to paragraph 131 of the Guidance and noted that the starting point for Dr Chauhan’s risk to public protection is high. However, the Tribunal went on to consider the relevant context known about the doctor or his working environment and how

Dr Chauhan responded to the Allegation and what impact this had on its assessment of current and ongoing level of risk on public protection.

79. The Tribunal considered that the particular circumstances surrounding his XXX and family, which led to the behaviour were unique, isolated and are now largely resolved. The end to a XXX and family arrangement has significantly reduced the emotional stressors on Dr Chauhan. It has also brought about an end to XXX that placed Dr Chauhan under serious financial pressure.

80. It noted the evidence from Dr Chauhan that he has put in place “*financial contingency planning*”, including an “*emergency fund to reduce the risk of financial desperation*”. Dr Chauhan gave evidence to the Tribunal about the change in his attitude to seek support should he find himself in a similar situation in the future. He identified “*services such as the BMA’s wellbeing support, the NHS practitioner Health Programme, and the GMC’s own confidential support line*”. The Tribunal noted the evidence that Dr Chauhan has asked his mother to move in with him to provide emotional and practical support and heard evidence from Dr I and Dr J of their commitment to continue to provide emotional support and professional guardrails.

81. This context was relevant when determining the level of current and ongoing risk that Dr Chauhan poses to public protection.

82. The Tribunal was satisfied that the risk of repetition was very low given the change in circumstances and safeguards that have been put in place to ensure that Dr Chauhan, even if faced with similar stresses, would react differently and in line with professional standards in the future.

83. The Tribunal then moved on to consider the exceptional insight and remediation work that Dr Chauhan had already undertaken and his plans to continue to work with Dr J each quarter, which is discussed at length above.

84. The Tribunal read through the plethora of evidence Dr Chauhan produced to the Tribunal to highlight his insight and remediation, this included but was not limited to:

- the report of Dr D,
- Dr Chauhan’s detailed reflective statements which he had prepared following work with Dr D,
- Dr Chauhan’s statement,

- The statement and oral evidence of Dr I,
- The record of professional values discussion signed by Dr J,
- The oral evidence of Dr J.

85. The Tribunal also noted that Dr Chauhan admitted all of the facts and accepted that his behaviour amounted to serious misconduct. He provided oral evidence which showed genuine remorse for his actions. He has provided detailed, in depth and thoughtful reflective pieces which show a deep understanding of his insight into his misconduct.

86. The Tribunal determined that there was no more work that could be reasonably expected of him to undertake in order to develop his insight or remediate his behaviour. The Tribunal had to balance this against the original level of seriousness found. The Tribunal noted that, given the Allegation fell at the higher end of the spectrum of seriousness, the weight given to the context and how Dr Chauhan responded may carry less weight. However, they do carry weight and must be considered.

87. The Tribunal was of the view that the risk to public protection must be reduced, and it considered that it would be demonstrably disproportionate and unfair for the Tribunal not to place the appropriate weight on the exemplary work Dr Chauhan has undertaken to gain insight, remediate his actions and reduce the likelihood of repetition.

88. Therefore, the Tribunal determined that in balancing the seriousness of this dishonest behaviour against the genuine remorse, insight, remediation and low risk of repetition, the risk to public protection was not high.

89. The Tribunal determined that the level of risk to current and ongoing public protection must reduce to be “medium”.

Protect, maintain and promote the safety and wellbeing of the public

90. The Tribunal accepted that Dr Chauhan has kept his clinical knowledge and skills up to date. The Tribunal was of the view that although his actions may have increased a risk to patient safety in 2023, his insight and remediation, along with maintaining his skills up to date, reflect that there are no current concerns surrounding patient safety or the safety and wellbeing of the public.

Promoting and maintaining public confidence in the profession

91. The Tribunal found that Dr Chauhan’s misconduct had breached a fundamental tenet of the medical profession and brought it into disrepute. The public must have confidence that doctors will act with honesty and integrity.

92. Dr Chauhan accepted that *“the general public would not be happy about a clinician working for two organisations simultaneously”*. He was deliberately dishonest to more than one organisation for financial gain. The Tribunal found that the public would find his behaviour to be deplorable.

93. The Tribunal determined that a finding of impairment was necessary to maintain confidence in the profession.

Promoting and maintaining professional standards of conduct

94. The Tribunal considered paragraph 42 of the *Guidance* which sets out *“if a doctor seriously departs from the professional standards, it can mean that they pose a risk to public protection.”*

95. The Tribunal found that Dr Chauhan’s conduct was a serious departure from the standard of conduct expected of medical practitioners. It was of the view that members of the profession with knowledge of the misconduct would consider that Dr Chauhan had fallen significantly below the standard expected of a medical practitioner.

96. The Tribunal also considered paragraph 44 of the *Guidance* which sets out *“a departure from the professional standards may require regulatory action to uphold them. This is because regulatory action sends a message to the individual doctor, the wider profession, patients and members of the public about the principles, values, and standards of care and professional behaviour expected of doctors”*.

97. The Tribunal considered that a finding of impairment is required to send a clear signal to Dr Chauhan, the profession and the public that the nature of his misconduct was unacceptable.

98. The Tribunal found that the *Grant* test was met: a finding of impairment was necessary to maintain public confidence in the profession, and uphold proper standards of conduct.

99. Accordingly, the Tribunal determined that Dr Chauhan’s fitness to practise is currently impaired as there remains a medium current and ongoing risk to public protection.

Determination on Sanction - 08/06/2026

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

The Evidence

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

Submissions

On behalf of the GMC

102. Mr Lodge submitted that the appropriate and proportionate sanction in this case was one of suspension. He directed the Tribunal to the new MPTS Sanction’s Guidance, section 3, part C, (‘the Guidance’) which provided the framework for determining sanction by reference to the nature of the Tribunal’s findings and its assessment of the current and ongoing risk to public protection. He drew attention to paragraph 60, which requires the Tribunal to consider, where available, the sanctions banding for specific case types. Dishonesty appears expressly within that banding table and, for cases assessed as presenting a medium level of risk to public protection, the suggested sanction is suspension for a period of three to nine months.

103. Mr Lodge submitted that taking no action would be inappropriate and the Guidance made it clear that, although context, insight and remediation were relevant, they were unlikely on their own to justify taking no action. While there was significant context in this case and what had been described as exceptional insight and remediation, he submitted that these factors did not amount to exceptional circumstances capable of justifying no further action and the public interest would not be met by such an outcome. Turning to conditions, Mr Lodge referred to paragraph 17 of the Guidance and submitted that none of the factors indicating that conditions might be appropriate were present. Further, conditions would not

address the specific concerns arising from Dr Chauhan’s dishonest conduct, particularly the need to maintain public confidence in the profession and uphold proper standards. In this case, Mr Lodge submitted that conditions would be unmeasurable, unworkable and simply inappropriate.

104. Mr Lodge submitted that suspension was the proportionate and necessary outcome. The Guidance explained that suspension was appropriate where a doctor’s behaviour was currently incompatible with unrestricted registration, such that the ongoing risk to public protection must be managed by restricting registration for a period, with the aim of enabling a safe return to practice. Paragraph 45 identified factors relevant to suspension, including where conditions were not appropriate and where, although patient safety was not at issue, suspension was required to maintain public confidence or uphold standards. Mr Lodge submitted that this case fell squarely within that category.

105. Mr Lodge submitted that if the Tribunal determined that suspension was appropriate, it would then need to consider length. The Tribunal had found the current and ongoing level of risk to be medium in this case and Mr Lodge directed it to paragraphs 46, 47 and 63 of the Guidance to determine the length of suspension. Mr Lodge highlighted that paragraph 47 contemplated circumstances in which a short suspension may be appropriate and may be applicable here. However, the Tribunal must also consider the dishonesty banding, which placed the appropriate range at three to nine months.

106. Mr Lodge submitted that the seriousness of the departure from Good Medical Practice (‘GMP’), the deplorable nature of the dishonest behaviour, and the aggravating features identified justified an upward adjustment within that range. Mitigating factors, including the absence of patient safety concerns, the lack of previous dishonesty and the context of the misconduct, had already been taken into account when assessing risk as medium rather than high. He submitted that a suspension was necessary to maintain public confidence in the profession and send a clear message to the doctor, to other practitioners and to the public. He submitted that erasure would be wholly disproportionate given the significant mitigating factors and the fact that Dr Chauhan’s behaviour was not incompatible with continued registration.

107. Mr Lodge submitted that any review would relate only to ensuring that Dr Chauhan’s knowledge and skills remained up to date, depending on the length of suspension, and not to further assessment of insight or remediation.

On behalf of Dr Chauhan

108. Mr Gledhill submitted that the appropriate sanction in this case was a period of suspension. He invited the Tribunal to impose a suspension of three to four months as such a period represented the most proportionate response when viewed against the Tribunal's findings at the impairment stage. Mr Gledhill emphasised that the Tribunal had already identified the extensive remediation undertaken by Dr Chauhan, noting that it was of a high level and that he could not realistically have done more.

109. Mr Gledhill submitted that a review hearing would not be necessary. Dr Chauhan was not returning to practise in the United Kingdom for some time, was keeping his knowledge up to date in his current role abroad, and would ensure that any future employer was informed of his period out of UK practice. Accordingly, there would be no need for a review to assess competence or remediation.

110. Mr Gledhill submitted that erasure would be wholly disproportionate to the issues and findings in the case and invited the Tribunal not to consider erasure as a viable option. He reminded the Tribunal of the submissions he had made at the impairment stage, which remained relevant. He wanted to provide additional information to the Tribunal specifically in relation to the £8,500 gained. Dr Chauhan had spoken to his employer and discussed the matter and they had not required repayment, and that the money had assisted Dr Chauhan during a period of significant financial difficulty. Further, Dr Chauhan had apologised and had since recovered from the instability he faced at that time, with his family life now more settled.

111. Addressing future risk, Mr Gledhill submitted that the Tribunal had already assessed the risk of repetition as low, and he submitted that in reality it was negligible. Dr Chauhan had reflected deeply on his conduct and had experienced considerable embarrassment in having to discuss the matter with his colleagues, Dr J and Dr I. Dr Chauhan had recognised that he had been under significant pressures at the time but was now in a different frame of mind and would, in future, reach out to colleagues for support when under strain. He regarded the misconduct as an abhorrent period in his past and was determined never to repeat it. His initial denial when first confronted had been a spontaneous, panicked reaction, which he regretted. Mr Gledhill submitted that, while that denial might be viewed as an aggravating feature, it formed part of the same overall period of misconduct and should not be given disproportionate weight when determining the length of suspension.

112. Mr Gledhill observed that Mr Lodge had not proposed a specific length of suspension on behalf of the GMC. While Mr Lodge's submissions might point towards a mid-range period

of around six months, Mr Gledhill submitted that a lower-end suspension of three to four months was more proportionate.

The Tribunal's Approach

113. The Tribunal had regard to the relevant sections of the Guidance.

114. In making its decision on sanction the Tribunal was reminded it must consider what in light of its findings of impairment is the proportionate response, needed to protect the public. The Tribunal had determined that two aspects of public protection were engaged in this case, and it has now to consider what regulatory action, if any, is needed to maintain public confidence in the profession and to promote and maintain proper professional standards and conduct for members of the profession. The Tribunal referred to the sanctions banding as set out in the Guidance and considered the level of current and ongoing risk the doctor poses to public protection. It also considered the impact of any specific sanction type, where applicable, and any other relevant factors or information that would inform its decision.

115. The Tribunal noted that should it make a decision that was outside of the Guidance, it must provide clear, detailed and cogent justification for that decision, given the specific circumstances of the case.

116. The Tribunal noted that the decision as to the appropriate sanction, if any, to impose was a matter for its independent judgement which it must exercise fairly, transparently and proportionately. The purpose of a sanction is not to punish the doctor, although any sanction imposed may have a punitive effect.

117. The Tribunal reminded itself that, in determining whether to impose a sanction, it should have regard to the principle of proportionality and should start by considering the least restrictive option and impose a sanction that is no more restrictive than necessary for public protection.

118. The Tribunal has also applied the principle of proportionality, balancing Dr Chauhan's interests with the public interest.

119. In relation to a review, the LQC referred the Tribunal to paragraph 52 of the Guidance:

“52. The question of whether the doctor can safely return to unrestricted practice will need to be considered before a period of suspension concludes and so a review should be directed. The exception to this is where a short suspension (usually three months or less) has been imposed on public confidence grounds and/or to maintain professional standards.”

The Tribunal’s Determination on Sanction

120. The Tribunal has had regard to the submissions of parties and its decision on impairment as to the level of current and ongoing risk Dr Chauhan poses to public protection.

121. The Tribunal further noted the sanctions bandings set out in the Guidance. The sanctions banding set out that, where there is a medium risk in cases of dishonesty, the common sanction was “Suspension 3 to 9 months”.

122. With this in mind, the Tribunal considered each of the available sanctions in turn, starting with the least restrictive.

No Action

123. The Tribunal first considered whether to conclude the case by taking no action. It considered the Guidance which related to taking no action.

124. The Tribunal determined that, although it had found that Dr Chauhan’s insight and remediation was exceptional, this did not equate to exceptional circumstances which would warrant the taking of no action in the context of the facts found proved and the Tribunal’s determination on impairment. It considered that the taking of no action would not be proportionate, or sufficient to protect the public.

Conditions

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

126. The Tribunal noted the sanctions banding for dishonesty did not indicate that conditions would be an appropriate and proportionate sanction.

127. The Tribunal had regard to the relevant section of the Guidance which provide an indication of cases where conditions are likely to be suitable. It reminded itself of its earlier findings that Dr Chauhan had breached fundamental tenets of the profession. In addition to the level of risk identified in this case the Tribunal concluded that Dr Chauhan’s misconduct could not be addressed by conditions on his registration.

128. The Tribunal determined that it was not possible to formulate conditions to address the risk of harm associated with Dr Chauhan’s dishonesty. Given the seriousness of Dr Chauhan’s conduct, and the inability to formulate proportionate, workable, appropriate and measurable conditions, the Tribunal concluded that the imposition of conditions would be insufficient to satisfy the wider public interest and would not be proportionate.

Suspension

129. The Tribunal then considered whether imposing a period of suspension on Dr Chauhan’s registration would be appropriate and proportionate. The Tribunal reminded itself the purpose of suspension is to remove a doctor from practice; to manage the current and ongoing risk they pose to public protection with the aim they should be able to return safely to unrestricted practice. Suspension can have a deterrent effect and be used to send a signal to the individual doctor, the profession and public about what is regarded as behaviour unbecoming a registered doctor.

130. The Tribunal further noted paragraphs 44 and 45 of the relevant section of the Guidance, which provided:

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

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

a conditions are not appropriate, measurable and/or workable

b the level of current and ongoing risk to public protection is such that it cannot be safely managed with conditions and suspension is necessary to stop the doctor from

*working and putting patients at risk while they gain insight into any deficiencies and remediate, or undergo medical treatment, and/or
c the level of current and ongoing risk to public protection is such that, although patient safety is not an issue, suspension is needed to maintain public confidence in the profession and/or maintain professional standards.'*

131. The Tribunal reminded itself of its findings at the impairment stage, that Dr Chauhan's misconduct presented a medium current and ongoing risk to public protection, but that patient safety was not a concern in this case. The Tribunal remained concerned with the second and third limbs of public protection, namely the need to maintain public confidence in the medical profession and the need to uphold proper professional standards and conduct.

132. When considering whether suspension was the appropriate sanction in this case, the Tribunal had regard to all of the circumstances and the sanctions banding, as set out above.

133. The Tribunal acknowledged that at the time of the events, the misconduct was serious. The behaviour had occurred as a result of significant personal stressors and had a contextual background. However, Dr Chauhan has gone to great lengths since to remediate and demonstrate insight, reduce the risk of repetition and express remorse for his behaviour.

134. The Tribunal noted that Dr Chauhan's conduct was contrary to GMP but agreed with the submissions made by both Mr Lodge and Mr Gledhill that it was not conduct that was fundamentally incompatible with continued registration. It determined that erasure would be a disproportionate response as it had assessed the level of current and ongoing risk to public protection of Dr Chauhan's misconduct as medium rather than high and the factors for erasure set out at paragraph 57 of the Guidance were not met.

135. The Tribunal reminded itself of Dr Chauhan's previously unblemished career without any fitness to practise concerns and was of the view that his dishonest conduct was outside of his normal character, had occurred under pressure, and that any repetition was unlikely. The Tribunal also took into account that there were no patient safety concerns in this case.

136. The Tribunal was satisfied, weighing all the factors, including the interests of Dr Chauhan against the need to meet the overarching objective, that a period of suspension was the appropriate and proportionate response in this case.

Length of Suspension

137. Having determined to impose a period of suspension on Dr Chauhan’s registration, the Tribunal went on to consider the length of the period of suspension.

138. The Tribunal noted the submissions of Mr Lodge that paragraph 47 of the Guidance may be applicable in this case. Paragraph 47 states:

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

139. The Tribunal was of the view that a suspension over the minimum was needed to mark the seriousness of Dr Chauhan’s misconduct, which it found had been premeditated, repeated over a number of months, recklessly disregarded professional standards, and which was covered up by Dr Chauhan when he was initially challenged.

140. However, The Tribunal considered that a long period of suspension would be disproportionate given the circumstances surrounding the occurrence of the misconduct, the work that Dr Chauhan had undertaken to develop his insight and remediate his actions, and that it was unlikely that Dr Chauhan would repeat his misconduct. The Tribunal considered that four months would be appropriate to send a message to both the doctor and the profession, and to address the public interest in this case.

Review hearing

141. The Tribunal then went on to consider whether or not to direct a review.

Submissions

On behalf of the GMC

142. Mr Lodge highlighted paragraph 52 of the Guidance.

143. Mr Lodge submitted that, in light of the length of the suspension and that Dr Chauhan is not in regular practise, the Tribunal may find that a review hearing is appropriate.

On behalf of Dr Chauhan

144. Mr Gledhill submitted that a review is not necessary in this case. He said that, where there is a suspension of six months or more, the assistant registrar has the right to impose a review and that was perhaps guidance as to when one was needed. He submitted that four months was not close to the six-month threshold.

The Tribunal's Decision

145. The Tribunal had regard to the Guidance which sets out that no doctor should be allowed to resume unrestricted practice following a period of suspension unless the Tribunal considers that they are safe to do so. The Guidance states that in some cases it may be self-evident that, following a short suspension, there will be no value in a review hearing but that in most cases, the Tribunal will need to be reassured that the doctor is fit to resume practice.

146. The Tribunal noted that the purpose of a review hearing is to ensure that a doctor is fit to resume unrestricted practice. The review hearing would consider Dr Chauhan's insight into his misconduct, whether he has kept his skills and knowledge up to date, and if there is any risk to patient safety.

147. The Tribunal has already determined that Dr Chauhan has evidenced exceptional insight into his misconduct and there is little more he can do to evidence remediation. Therefore, a review hearing would not be necessary in relation to this aspect.

148. The Tribunal considered that Dr Chauhan has kept his skills and knowledge up to date as evidenced in his CPD log. The Tribunal noted that Dr Chauhan works in the United States in a managerial role. It heard submissions that Dr Chauhan may seek to return to clinical practise in the UK, but not in the near future. A review hearing would take place in approximately three months time, at which point the review Tribunal would be presented with similar evidence, showing his up-to-date skills and knowledge. Therefore, a review to consider this aspect would be disproportionate.

149. The Tribunal has already determined that Dr Chauhan does not pose a current or ongoing risk to the safety and wellbeing of the public. Therefore, a review hearing would not be required to consider this aspect of public protection.

150. The Tribunal bore in mind the Guidance at paragraph 52, which set out the exception to when a review hearing is required. Firstly, a review hearing may not be required where a

short period of suspension has been imposed. A short period of suspension being noted as “usually three months or less”. The Tribunal found that four months is only marginally longer than the three months as set out in the guidance. Secondly, “the period of suspension was only imposed on public confidence grounds and/or to maintain professional standards”. The Tribunal noted that this was the case for Dr Chauhan.

151. The Tribunal considered all the circumstances of this case and was satisfied that a review hearing would not be required given the level of insight, the low risk of repetition, the length of the suspension, Dr Chauhan’s up to date skills and knowledge, and that there is no identified risk to patient safety. It determined that a review hearing would not be necessary nor proportionate in this case.

Determination on Immediate Order - 08/06/2026

152. Having determined that Dr Chauhan is to have his registration suspended for a period of four months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Chauhan’s registration should be subject to an immediate order.

Submissions

On behalf of the GMC

153. Mr Lodge submitted the GMC do not seek an immediate order in this case. He referred to paragraph 84 of the *MPTS Guidance for Tribunals (the MPTS Guidance) (MPT Hearings > Part C: stage three – sanction > Step 3: decide on sanction)* (‘the Guidance’).

154. Mr Lodge submitted that there are no factors present which would require the Tribunal to direct that an immediate order is necessary in the public interest.

On behalf of Dr Chauhan

155. Mr Gledhill submitted that an immediate order is not necessary.

156. Mr Gledhill submitted that an immediate order is often required where there is a public protection element needed and there was no public protection element needed here.

157. Mr Gledhill reminded the Tribunal of its findings in relation to remediation and insight, that there was not much more Dr Chauhan could have done, and therefore the need for an immediate order was not required.

The Tribunal's Determination

158. The Tribunal considered paragraph 84 of the MPTS Guidance regarding when immediate orders should be imposed.

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

- a. the doctor poses a risk to patient safety*
- b. the risk to one or more parts of public protection is high, and/or*
- c. immediate action is needed to maintain public confidence in the medical profession.'*

159. The Tribunal noted that Dr Chauhan is not working in the UK, he is not formally working in medicine, rather he is in a management role in Hawaii.

160. The Tribunal considered all the evidence adduced in this case, including its findings on impairment and sanction. It noted that there are no concerns regarding patient safety, the risks identified to public protection are assessed to be medium, and it took the view that immediate action is not needed to uphold professional standards or maintain public confidence in the medical profession. Furthermore, there was no evidence that an immediate order would be in the best interests of Dr Chauhan. The Tribunal therefore determined that, in all the circumstances of this case, an immediate order was not necessary.

161. This means that Dr Chauhan'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 Chauhan does lodge an appeal, he will remain free to practise unrestricted until the outcome of any appeal is known.

162. There is no interim order to revoke.

163. That concludes this case.

SCHEDULE 1

1. 03/03/2023
2. 04/03/2023
3. 12/03/2023
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5. 17/03/2023
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