Record of Determinations –
Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 01/04/2019 - 24/04/2019
Medical Practitioner’s name: Dr Ankur CHOPRA

GMC reference number: 5189011
Primary medical qualification: MB BS 1995 Manipal Academy

Type of case
New - Misconduct
New - Deficient professional performance

Outcome on impairment
Not Impaired
Not Impaired

Summary of outcome
No warning

Tribunal:

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<tr>
<th>Role</th>
<th>Name</th>
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<tr>
<td>Legally Qualified Chair</td>
<td>Dr Matthew Fiander</td>
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<tr>
<td>Lay Tribunal Member:</td>
<td>Mr Stephen Marr</td>
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<td>Medical Tribunal Member:</td>
<td>Dr John Garner</td>
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<tr>
<td>Legal Assessor:</td>
<td>Mr Lindsay Irvine (1 April -12 April 2019)</td>
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<td>Mr Rob Ward (16 April - 14 April 2019)</td>
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<td>Tribunal Clerk:</td>
<td>Mr Matt O’Reilly</td>
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Attendance and Representation:

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<td>Medical Practitioner:</td>
<td>Present and represented</td>
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<td>Medical Practitioner’s Representative:</td>
<td>Mr Andrew Colman, Counsel, instructed by MDDUS</td>
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<tr>
<td>GMC Representative:</td>
<td>Ms Shirlie Duckworth, Counsel</td>
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**Attendance of Press / Public**

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

**Overarching Objective**

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

**Determination on Facts - 16/04/2019**

**Background**


2. The matters before the Tribunal relate to Dr Chopra’s alleged deficient professional performance with regard to nineteen patients. It is alleged that Dr Chopra’s failures relate to prescribing (eleven patients), record keeping (eleven patients) and assessment and treatment (eight patients). The Allegation relates to Dr Chopra’s consultations with patients from 11 May 2012 until 7 February 2017.

3. Dr Chopra was referred to the GMC in September 2015 through the GMC confidential helpline and was notified in correspondence dated 18 September 2015 by the GMC that because of concerns over his fitness to practise, NHS England were investigating concerns over patient safety, inappropriate prescribing, and inaccuracies in record keeping.

**The Outcome of Applications Made during the Facts Stage**

4. At the outset of the hearing Dr Garner informed the parties that he had previously worked with Dr AA in a professional capacity, though not for a number of years. Dr Garner also declared that he was a previous director and Vice Chairman of MDDUS who are instructing on behalf of Dr Chopra. Ms Duckworth and Mr Colman
were both satisfied that there was no conflict of interest. The Tribunal were satisfied that no conflict existed.

5. On day one of the hearing Ms Duckworth made an application pursuant to Rule 28 of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules') to amend one of the dates as set out in Schedule 1 in relation to Patient A, from 22 October 2014 to 31 October 2014. She submitted that the consultation on 22 October 2014 refers to a consultation with a different member of staff and the charge should reflect the consultation Patient A had with Dr Chopra one week later on 31 October 2014. Mr Colman made no objection to the proposed amendment. The Tribunal granted the application as there was no injustice to either party in doing so.

6. Ms Duckworth then made a further application pursuant to Rule 28(3) of ‘the Rules’, for paragraphs 40, 41, 42 and 43 of the Allegation to be withdrawn. She submitted that those heads of charge and the related ground of impairment be withdrawn as the GMC no longer consider there is sufficient evidence to support these paragraphs. Ms Duckworth also submitted that there were concerns as to the impact on the witness’s health and wellbeing in being called to give live evidence. Mr Colman made no objection. The Tribunal determined to grant the application there being no injustice to either party.

7. On day 3 of the hearing Ms Duckworth made an application to amend paragraph 21 of the Allegation and to withdraw paragraphs 23 and 24 pursuant to Rule 17(6) of the Rules. She submitted that following communication with Patient K it was clear that Patient K had been treated for hypertension prior to consulting Dr Chopra, the evidence now no longer supported the Allegation as drafted. Ms Duckworth also submitted that there were concerns as to the impact on the witness’s health and wellbeing in being called to give live evidence. Ms Duckworth proposed to amend paragraph 21a to represent record keeping, as opposed to prescribing concerns, and to withdraw paragraphs 23 and 24 as they were no longer supported by the evidence given the updated Joint Expert Report following the new information from Patient K. Mr Colman made no objection. The Tribunal determined to grant the application as there was no injustice to either party.

8. On day 5 of the hearing Ms Duckworth made an application to amend the Allegation pursuant to Rule 17(6) of the Rules. She submitted that the application was to add an alternative paragraph in relation to a recording error and associated necessary grammatical changes to sub-paragraphs 14a (i) and (ii). Mr Colman opposed the application submitting that the proposed amendment is to Dr Chopra’s prejudice as it adds a further allegation of which he was not notified in advance. The Tribunal determined to reject the application as the proposed amendment was a material change. Adding a further allegation and denying Dr Chopra an earlier
opportunity to address the Allegation, the Tribunal considered to be unfair. The Tribunal’s full determination can be found at Annex A.

9. On day 6, the Tribunal invited representations on a proposed amendment to paragraph 14b of the Allegation in relation to Patient G’s medical records, dated 8 August 2015. The Tribunal identified that the Allegation read that Dr Chopra prescribed co-cyprindiol ‘2000 mg’, but it noted Patient G’s medical record indicated the prescription of co-cyprindiol was for ‘2000/35 mg’. Neither party made any objection or submission in relation to the proposed amendment. The Tribunal therefore determined to amend paragraph 14b of the Allegation as it had proposed.

The Allegation and the Doctor’s Response

10. At the outset of these proceedings, through his counsel, Mr Colman, Dr Chopra made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of 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.

Patient A

1. On the dates in Schedule 1, you gave Patient A iron injections for anaemia. This was inappropriate in that you had not:
   a. established the cause of the anaemia; **Admitted and found proved**
   b. attempted oral iron as a first line treatment. **Admitted and found proved**

2. On 3 August 2015, you consulted with Patient A who had a diagnosis of constipation. The records of this consultation were inadequate in that you failed to record:
   a. a history of the symptoms including:
      i. duration; **Admitted and found proved**
      ii. frequency of bowel action; **Admitted and found proved**
      iii. description of stool; **Admitted and found proved**
iv. presence or absence of blood; **Admitted and found proved**

v. any weight loss; **Admitted and found proved**

vi. diet; **Admitted and found proved**

vii. fluid intake; **Admitted and found proved**

b. any advice given regarding:
   
i. diet; **Admitted and found proved**

   ii. laxative medication. **Admitted and found proved**

3. You prescribed oramorph 10mg/5ml oral solution up to four times per day as needed. This prescription was inappropriate in that oramorph can cause or worsen constipation. **Admitted and found proved**

4. Your referral to the gastroenterologist was not sufficient in that you failed to:
   
a. inform the specialist of Patient A’s medication history; **To be determined**

   b. update your referral following your consultations with Patient A on:

   i. 30 July 2015 with regard to Patient A suffering severe constipation due to the codeine; **To be determined**

   ii. 3 August 2015 with regard to prescribing Patient A oramorph. **To be determined**

**Patient B**

5. On 11 May 2012, you consulted with Patient B who had a diagnosis of hiatus hernia and had severe reflux. You prescribed pantoprazole 40mg twice a day, but you failed to arrange for appropriate reviews of this medication to take place. **Admitted and found proved**
6. On 28 April 2014, you consulted with Patient B and you prescribed esomeprazole 40mg twice daily. This prescription was contrary to the guidance contained in the British National Formulary. **Admitted and found proved**

7. On 3 August 2015, you consulted with Patient B and you prescribed a trial of domperidone 10mg tablet to be taken twice a day. This prescription was contrary to the guidance contained in the British National Formulary. **Admitted and found proved**

**Patient C**

8. On 3 August 2015, you:

   a. consulted with Patient C who had a new problem of solar keratosis. The records of this consultation were inadequate in that you failed to record:

      i. the location and size of the solar keratosis; **Admitted and found proved**

      ii. any advice given to Patient C; **Admitted and found proved**

      iii. any follow up plan you made; **Admitted and found proved**

   b. prescribed dovobet gel 60g. This prescription was inappropriate in that:

      i. dovobet gel is indicated for plaque psoriasis not solar keratosis; **Admitted and found proved**

      ii. the amount prescribed was excessive. **Admitted and found proved**

**Patient D**

9. On 3 August 2015, you consulted with Patient D who had a diagnosis of diarrhoea with cryptosporidium microscopy. The
records of this consultation were inadequate in that you failed to record any advice you had given to Patient D about:

a. handwashing; **Admitted and found proved**
b. cooking; **Admitted and found proved**
c. occupational risk. **Admitted and found proved**

**Patient E**

10. On 3 August 2015, you consulted with Patient E who had a diagnosis of severe cervical cord compression. The records of this consultation were inadequate in that you failed to record details of:

   a. ongoing incapacity; **To be determined**
   b. current symptoms; **To be determined**
   c. mobility; **To be determined**
   d. use of painkillers; **To be determined**
   e. actions precipitating pain (if any). **To be determined**

11. In not recording the information set out in paragraph 10 above, you failed to record the required clinical details to justify the issuing of Patient E’s ‘Certificate of Incapacity’ dated 6 August 2015. **To be determined**

**Patient F**

12. On 21 July 2015, you consulted with Patient F who had a diagnosis of a massive cellulitis on the left forearm. You failed to:

   a. measure the size of cellulitis; **To be determined**
   b. take Patient F’s:
      i. blood pressure; **To be determined**
      ii. pulse; **To be determined**
iii. temperature; **To be determined**

c. record:

i. the size of cellulitis; **To be determined**

ii. blood pressure; **Admitted and found proved**

iii. pulse; **Admitted and found proved**

iv. temperature. **Admitted and found proved**

13. On 3 August 2015, you consulted with Patient F. The records of this consultation were inadequate in that you failed to record details of:

a. your review of recent blood tests; **Admitted and found proved**

b. ongoing symptoms; **Admitted and found proved**

c. any examination you conducted. **To be determined**

**Patient G**

14. On 5 August 2015, you:

a. consulted with Patient G who you recorded as having a diagnosis of chronic depression. The records of this consultation were inadequate in that you failed to record details of any:

i. assessment of Patient G’s ongoing symptoms; **To be determined**

ii. examination you conducted; **To be determined**

b. prescribed co-cyprindiol 2000/35mg. This prescription was inappropriate in that:

i. an alternative contraception should have been offered; **To be determined**
ii. co-cyprindiol is not licensed as a primary contraceptive;  
   To be determined

iii. it was contrary to the guidance contained in the British National Formulary. To be determined

Patient H

15. On 5 August 2015, you:

a. consulted with Patient H who had a diagnosis of alcohol dependence syndrome and shingles. The records of this consultation were inadequate in that you failed to record the following details in relation to:

i. alcohol dependence syndrome:
   1. any assessment of Patient H’s psychological symptoms;  
      Admitted and found proved
   2. alcohol intake;  
      Admitted and found proved
   3. a treatment plan;  
      Admitted and found proved
   4. follow up care;  
      Admitted and found proved

ii. the shingles outbreak:
   1. its duration; To be determined
   2. its location; To be determined
   3. its extent; To be determined
   4. associated symptoms; To be determined
   5. follow up care. To be determined
b. prescribed acyclovir 200mg to be taken five times a day. This prescription was contrary to the guidance contained in the British National Formulary. **To be determined**

**Patient I**

16. On 4 August 2015, you consulted with Patient I who had a diagnosis of microalbuminuria. You prescribed Patient I perindopril. **Admitted and found proved**

17. On 5 August 2015, you consulted with Patient I. You:

   a. prescribed Patient I losartan; **Admitted and found proved**

   b. failed to record details of the exact nature of Patient I’s adverse reaction to perindopril. **Admitted and found proved**

18. The prescriptions at paragraphs 16 and 17(a) were inappropriate in that neither medication was clinically indicated. **Admitted and found proved**

**Patient J**

19. On 1 March 2016, you consulted with Patient J’s daughter in Patient J’s absence. This was inadequate in that you failed to assess:

   a. Patient J’s condition face to face; **To be determined**

   b. whether Patient J was:

      i. suffering from a pulmonary embolism; **To be determined**

      ii. seriously ill. **To be determined**

20. The record of your consultation with Patient J’s daughter, referred to at paragraph 19, was inadequate in that you failed to record:

   a. a history; **Admitted and found proved**
b. advice about when Patient J should attend for a further assessment; **Admitted and found proved**

c. what warning signs Patient J should look for that would indicate the need for urgent reassessment. **Admitted and found proved**

**Patient K**

21. On 11 November 2015, you consulted with Patient K during which you prescribed losartan 50mg. The records of this consultation were inadequate in that you:

   a. recorded this as a first consultation for hypertension, when the patient had been attending at the practice for management of his blood pressure since September 2013; **Admitted and found proved**

   b. failed to record;

      i. that the patient was doing home readings to monitor his blood pressure; **Admitted and found proved**

      ii. what the home readings were. **Admitted and found proved**

22. On 15 January 2016, you consulted with Patient K and changed the prescription to candesartan 32 mg. This prescription was inappropriate in that:

   a. the losartan should have been increased to 100mg instead; **Admitted and found proved**

   b. the dose of candesartan was too high. **Admitted and found proved**

23. On 2 February 2016, you consulted with Patient K and you reduced the dose of candesartan to 16mg, which was an insufficient reduction. **Withdrawn**

24. On 4 March 2016, you consulted with Patient K. Patient K’s blood pressure reading was 121/66. You:
a. failed to reconsider the original diagnosis of essential hypertension; **Withdrawn**

b. failed to consider stopping all treatment; **Withdrawn**

c. placed Patient K at risk of having too low a blood pressure. **Withdrawn**

**Patient L**

25. On 25 November 2015, Patient L had a HbA1C blood test. Following receipt of the blood test result you failed to:

a. code the test results correctly in the records; **Admitted and found proved**

b. diagnose Patient L with diabetes; **Admitted and found proved**

c. treat Patient L for diabetes. **Admitted and found proved**

26. In March 2016, Patient L had a glucose tolerance test the result of which you failed to code correctly. **Admitted and found proved**

**Patient M**

27. On 11 April 2016, you consulted with Patient M and you failed to:

a. arrange a face to face consultation with Patient M; **To be determined**

b. properly assess Patient M; **To be determined**

c. record any safety netting. **Admitted and found proved**

**Patient N**

28. On 11 April 2016, you consulted with Patient N by telephone and you failed to:

a. take a sufficiently detailed history so as to assess the:
i. reason for the fall; **Admitted and found proved**

ii. the adverse effects from the fall; **Admitted and found proved**

b. arrange for a face to face consultation in order to exclude:

i. any significant head injury; **Admitted and found proved**

ii. a faint associated with the medication for hypertension; **Admitted and found proved**

iii. a seizure; **Admitted and found proved**

iv. an assault, given Patient N’s history of domestic violence; **Admitted and found proved**

c. provide appropriate warnings about what further symptoms should cause Patient N to seek urgent hospital attention. **To be determined**

**Patient O**

29. On 27 April 2016, you consulted with Patient O during which you prescribed losartan 50mg. This prescription was inappropriate in that you:

a. prescribed a dose that was too high for a person of Patient O’s age; **Admitted and found proved**

b. exposed Patient O to the risk of sudden drop in blood pressure and attendant falls. **Admitted and found proved**

30. The record of your consultation referred to at paragraph 29 was inadequate in that it was not clear whether Patient O was already taking losartan or whether you had initiated this. **Admitted and found proved**

**Patient P**

31. On 26 April 2016, you:
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a. consulted with Patient P. The records of that consultation were inadequate in that you failed to record:
   Admitted and found proved

   i. an adequate history regarding urinary problems such as whether Patient P had:

      1. pain on passing urine;
         Admitted and found proved

      2. problems with his urine stream;
         Admitted and found proved

   ii. the duration of the symptoms;
        Admitted and found proved

   iii. any examination undertaken;
        To be determined

b. failed to:

   i. conduct a proper assessment of Patient P in that you did not:

      1. examine Patient P;
         Admitted and found proved

      2. take a comprehensive history;
         Admitted and found proved

   ii. check Patient P’s PSA results and/or arrange for a further test; Admitted and found proved

   iii. put yourself in a position to:

      1. formulate a treatment plan;
         Admitted and found proved

      2. enable a definitive diagnosis to be made.
         Admitted and found proved

32. On 22 June 2016, you:

MPT: Dr CHOPRA
a. consulted with Patient P. The records of that consultation were inadequate in that you failed to record:

i. an adequate history regarding urinary problems such as whether Patient P had:
   1. pain on passing urine;  
      Admitted and found proved
   2. problems with his urine stream;  
      Admitted and found proved

ii. the duration of the symptoms;  
    Admitted and found proved

iii. any examination undertaken;  
     To be determined

b. failed to:

i. conduct a proper assessment of Patient P in that you did not:
   1. examine Patient P;  
      Admitted and found proved
   2. take a comprehensive history;  
      Admitted and found proved

ii. arrange a PSA test for Patient P;  
    Admitted and found proved

iii. put yourself in a position to:
   1. formulate a treatment plan;  
      Admitted and found proved
   2. enable a definitive diagnosis to be made.  
      Admitted and found proved

Patient Q
33. On 2 March 2016, you consulted with Patient Q during which you prescribed candesartan 16mg and indapamide 2.5mg. This prescription was inappropriate in that:
   a. it exceeded the usual starting dose of candesartan;  
      **To be determined**
   b. the combination of the two drugs placed Patient Q at risk of low blood pressure and attendant falls.  
      **To be determined**

34. You had further consultations with Patient Q on:
   a. 24 March 2016; **Admitted and found proved**
   b. 5 April 2016; **Admitted and found proved**
   c. 27 April 2016. **Admitted and found proved**

35. At each of the consultations referred to at paragraph 34 you:
   a. failed to review Patient Q’s blood pressure medication appropriately; **To be determined**
   b. placed Patient Q at risk of low blood pressure and attendant falls. **To be determined**

**Patient R**

36. You consulted with Patient R on the following dates:
   a. 6 July 2015; **Admitted and found proved**
   b. 2 February 2016; **Admitted and found proved**
   c. 28 June 2016. **Admitted and found proved**

37. At each of the consultations set out in paragraph 36, you prescribed aciclovir for the treatment of shingles, the details of which are set out at Schedule 2.  
   **Admitted and found proved**
38. The prescriptions as detailed in Schedule 2 were inappropriate in that you:
   a. did not prescribe the correct dose in line with the British National Formulary; **Admitted and found proved**
   b. put Patient R at:
      i. risk of incomplete and inadequate treatment; **Admitted and found proved**
      ii. increased risk of post herpetic neuralgia. **Admitted and found proved**

**Patient S**

39. On 7 February 2017, you consulted with Patient S during which you prescribed metformin 1.5g twice a day. This prescription was inappropriate in that you:
   a. exceeded the maximum dose as set out in the British National Formulary; **Admitted and found proved**
   b. exposed Patient S to the risk of significant and potentially dangerous side effects. **Admitted and found proved**

**Ms T**

40. On an unknown date between 12 February 2016 and 24 August 2016, you asked Mrs T to make an audit sheet with various dates in 2014 and 2015 written on it. The audit trail produced indicated that Mrs T had:
   a. checked the medical bag, when she had not; **Withdrawn**
   b. updated the items in the medical bag, when she had not. **Withdrawn**

41. The audit trail thereby produced was false. **Withdrawn**

42. On 23 August 2016, in relation to an emergency drug bag that was not returned on 21 October 2015, you said to Ms T “So, can we say you were here on this day?”, or words to that effect. **Withdrawn**
43. Your actions at paragraph 41 and 43 above were dishonest as you knew Ms T:

a. was not an employee until 2016; **Withdrawn**

b. could not have carried out the tasks in 2014 and 2015. **Withdrawn**

11. 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.

**Factual Witness Evidence**

12. The Tribunal received evidence on behalf of the GMC in the form of a witness statement from the following witness who was not called to give oral evidence:

- Patient P.

13. Dr Chopra provided his own witness statement, dated 18 March 2019. He also gave the Tribunal oral evidence at the hearing.

**Expert Witness Evidence**

14. The Tribunal also received evidence from three expert witnesses.

- Dr AB provided three Expert Reports, dated 10 October 2016, 1 December 2016 and 2 October 2017, on behalf of the GMC. Dr AB also provided two supplementary Expert Reports, dated 22 November 2018 and 1 February 2019. In addition to this, Dr AB also provided a Joint Expert Report, dated 7 March 2019, with Dr AC. Dr AB also provided oral evidence.

- Dr AA provided two Expert Reports, dated 2 December 2017 and 21 January 2018. Dr AA also provided a Joint Expert Report, dated 14 March 2019 with Dr AC, as set out above. In addition, Dr AA provided a Supplementary Report, dated 3 April 2019 and gave oral evidence.

- Dr AC provided an Expert Report, dated 28 February 2019, on behalf of Dr Chopra, Dr AC also provided a Joint Expert Report with Dr AB, dated 7 March 2019 as set out above. Additionally, Dr AC also provided a Joint Expert Report, dated 14 March 2019, with Dr AA. Dr AC also provided oral evidence.

**Documentary Evidence**

**MPT:** Dr CHOPRA
15. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included, but was not limited to:

- Dr Chopra’s Rule 7 response;
- Medical records relating to the 19 Patient’s;
- NHS Litigation Authority Re: Dispute Resolution Regarding A Personal Dental Service Agreement Between the BargainDentist.com and NHS England, dated 30 December 2013.

The Tribunal’s Approach

16. 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 Chopra 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.

17. In relation to those Allegations which allege a failure on Dr Chopra’s part to act in a certain way or allege that he acted in a way when he should not have, before any finding of failure, the Tribunal satisfied itself of the existence of a relevant duty or obligation on him to act in a certain way and determined whether that duty had been fulfilled with reference to the standards set down in professional practice guidelines including Good Medical Practice (2013) (‘GMP’) and the expert evidence in reports or in oral testimony.

18. The Tribunal noted that the case of the NHS Litigation Authority case cited above, produced by Mr Colman on behalf of Dr Chopra was not a decided legal authority but the determination of a dispute resolution. However, in the absence of an objection by Ms Duckworth and on the advice of the legal assessor, the Tribunal gave due weight to the principle in the dispute resolution determination that just because an action had not been recorded did not in itself prove that it had not been done.

The Tribunal’s Analysis of the Evidence and Findings

19. 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.

The Experts

20. The Tribunal considered that all three experts in this case were of considerable assistance. In the reports and oral testimony they demonstrated extensive knowledge and experience in general practice and they each did their best to assist the Tribunal. Notably, they sought to achieve consensus where their

MPT: Dr CHOPRA
opinions differed. All three made appropriate concessions and where they differed, set out clearly the rationale for their divergence.

21. In the Tribunal’s assessment Dr AB tended to adopt a standard which might be considered at the higher end of the spectrum. The Tribunal noted that in benchmarking what he considered to be the required standard, he referred to the training environment where understandably a pure approach tending towards best, rather than standard practice might be regarded as the norm.

22. The Tribunal considered that Dr AC on other hand tended towards a more pragmatic approach, more relevant and consistent with the pressures and realities of busy general practice. They found his explanations and preparedness to give ground to Dr AB on occasion lent additional authority to his opinions.

23. Dr AA had assessed fewer cases and his oral evidence was shorter than those of his colleagues, largely adopting what he had said in his written reports.

24. The Tribunal noted that Dr Chopra’s oral evidence was largely consistent with his written witness statement. Whilst the Tribunal appreciated that giving formal evidence in a hearing is a daunting experience, it was concerned that when asked to explain or develop the reasons he had put forward for prescribing, treating or recording deficiencies, he appeared at times vague and reticent notwithstanding his reasonable proficiency in the workings of the Practice computer system. Whilst the Tribunal did not consider the reticence suggested deliberate evasiveness, it made his answers in relation to certain matters less convincing when his credibility was an important issue in the Tribunal’s assessment of the facts.

Patient A

Allegation 4

4. Your referral to the gastroenterologist was not sufficient in that you failed to:

   a. inform the specialist of Patient A’s medication history;

   Found not proved.

25. This paragraph of the Allegation concerns Dr Chopra’s referral by letter, dated 22 July 2015, of Patient A to a consultant gastroenterologist.

26. The Tribunal first considered whether Dr Chopra had a duty to inform the specialist of Patient A’s medication history. It had regard to paragraph 44a of GMP which stated:

MPT: Dr CHOPRA
"44. You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means you must:

a. share all relevant information with colleagues involved in your patients’ care within and outside the team, including when you hand over care as you go off duty, and when you delegate care or refer patients to other health or social care providers.\(^5\)\(^10\)"

"5 General Medical Council (2013) Delegation and referral London, GMC"

27. GMC Delegation and referral, London (22 April 2013) stated:

9. The following applies whether you are delegating or referring.

... 

b. You must pass on to the healthcare professional involved:

...

• The purpose of transferring care and/or the investigation, care or treatment the patient needs.”

28. The Tribunal noted there was common ground between the experts that Dr Chopra was under a duty to inform the consultant gastroenterologist of Patient A’s medication history but they were divided as to the form this should take.

29. Dr AB was of the view that it was necessary for Dr Chopra to have either included the medication history in the body of the referral letter or to have mentioned in it that the medications history was included as an attachment.

30. Dr AC, on the other hand, considered that whilst it would have been courteous to do so as Dr AB suggests, it was sufficient for Dr Chopra to have included the medication history as an attachment without having specifically referred to the attachment in the body of the letter. It was Dr AC’s view that there is a range of opinion among medical practitioners in this regard.

31. The Tribunal had careful regard to the guidance contained within GMP and ‘Delegation and referral’ and determined that it prefers Dr AC’s opinion that so long as the medication history was attached to the referral letter, the specialist would have the relevant medication history.

32. The Tribunal then considered what Dr Chopra’s actions were in this regard.
33. The Tribunal noted that in his witness statement, dated 18 March 2019, Dr Chopra asserted that Patient A’s medication history would have been sent along with the referral as a matter of routine practice. Dr Chopra repeated this in his oral evidence and he was questioned at some length about the procedures in place at the practice. He maintained that referral letters, whether urgent or routine, would always be accompanied by the patients’ medication history.

34. It was the GMC’s case that, based on an earlier letter to a consultant haematologist regarding Patient A in which the attachment is referred to in the body of the letter, the fact that it was not referred to in the index referral letter indicates that the medication history was not in fact included.

35. The Tribunal had regard to referral letters of other patients contained within the bundle and noted that there was no consistent approach in the wording of those referral letters.

36. In the absence of the relevant hospital records which might have confirmed whether Patient A’s medication history was attached, the Tribunal was not satisfied, on the balance of probabilities, that Dr Chopra had not included Patient A’s medication history with his referral letter of 22 July 2015.

37. For the reasons set out above, the Tribunal finds paragraph 4a of the Allegation not proved

b. update your referral following your consultations with Patient A on:

   i. 30 July 2015 with regard to Patient A suffering severe constipation due to the codeine; Found not proved

   ii. 3 August 2015 with regard to prescribing Patient A oramorph. Found not proved.

38. The Tribunal first of all noted the duty set out in GMP and ‘Delegation and referral’ mentioned above.

39. The Tribunal then noted Dr Chopra’s view as set out in his witness statement that it was not practical to keep updating referrals unless the clinical condition has deteriorated and/or a reason is given to expedite the referral.
40. The Tribunal then had regard to the experts’ opinions noting that again they disagreed on the relevant standard to be met.

41. Dr AB, in his report of 1 February 2019, considered that the constipation recorded in Patient A’s medical notes on 30 July 2015 and the prescription of oramorph on 3 August 2015, both subsequent to the referral letter, should have been shared with the consultant. Dr AB maintained this position in his oral evidence.

42. Dr AC stated:

"...It would have been good practice to update the referral however constipation is an extremely common side-effect of opioid medication and I do not consider that all responsible General Practitioners would have informed the specialist."

43. Dr AC took the same position in relation to the prescription of oramorph and maintained these views in his oral evidence.

44. Whilst the Tribunal envisioned cases where GMP would mandate an update to the consultant, given that this was an urgent referral for anaemia and the short timescales involved between the prescribing and the patient presenting to the hospital consultant, the Tribunal preferred Dr AC’s opinion based on his assessment of what a reasonably body of practitioners would have done in similar circumstances.

45. The Tribunal was satisfied, on the balance of probabilities, that in not updating the specialist, Dr Chopra was not in breach of a duty.

46. The Tribunal therefore finds paragraph 4b (i) and (ii) of the Allegation not proved.

**Patient E**

**Allegation 10**

10. On 3 August 2015, you consulted with Patient E who had a diagnosis of severe cervical cord compression. The records of this consultation were inadequate in that you failed to record details of:

   a. ongoing incapacity; **Found proved**  
   b. current symptoms; **Found not proved**
c. mobility; **Found not proved**

d. use of painkillers; **Found not proved**

e. actions precipitating pain (if any) **Found not proved**.

47. This Allegation concerned a patient whose medical records indicated a number of co-morbidities. These included a long-term disability related to severe cervical cord compression. Dr Chopra was asked to sign a Certificate of Incapacity in relation to Patient E for an insurance company to confirm the patient’s ongoing occupational incapacity until age 55.

48. The Tribunal first considered if there was a duty for Dr Chopra to record the details set out in the matters listed in subparagraphs a-e of paragraph 10 of the Allegation. It first of all had regard to GMP Paragraph 21 which states:

"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…"

49. The Tribunal considered Dr AB’s Expert Report in which he stated that whilst he had no issue with the information contained in the certificate itself, he was:

"critical of the record entry dated 6 August 2015 which has no clinical information associated with the decision to issue the certificate".

He went on to note that:

"There is a record of a consultation for a well man review on 3 August 2015 which also contained no clinical information although it indicated that it was a general health review."

50. The Tribunal noted the following view expressed by Dr AB in his further report:

"In my opinion, one of these entries should have contained appropriate current clinical information. In my opinion, this demonstrated a standard of record keeping below that expected of a reasonably competent general practitioner. It gave subsequent clinicians no yardstick to judge Patient E’s
progress. In this case, in my opinion, it was below rather than seriously below the standard because it did not put Patent E at risk of significant harm.”

51. Dr AB stated in his oral evidence that there has to be specific information on the day of a consultation made in the medical notes. He gave an example that if a doctor was hit by a bus, the medical notes should be such that it would not take much for a subsequent treating doctor to know what might have happened in the interim.

52. The Tribunal next considered the Expert Report of Dr AC in which he stated:

“This was a telephone consultation. It is likely that Patient E was requesting a certificate. This was an ongoing problem. There is evidence that he did have cord compression. He had been under a Neurologist and had been referred to a Neurosurgeon. This was an ongoing certificate confirming the reason he was unable to work. There was no indication to record current symptoms, mobility, use of painkillers and the requirement for analgesia. Patient E was requesting a certificate to confirm the reason why he was unable to work.”

53. In the Joint Expert Report, Dr AB and Dr AC stated:

“All allegations 10 (a), (b), (c), (d) and (e)

Dr AC and Dr AB both agree that on the record, Dr Chopra failed to appropriately ask and record the information set out in the allegations and his actions were below the standard expected.”

However, in his oral evidence the Tribunal noted that Dr AC reverted to his original opinion that Dr Chopra would have made an adequate record of the consultation if he had recorded “one line” such as “no change”.

54. The Tribunal noted that both experts agree that Dr Chopra should have made some record, even one line stating ‘no change’. It considered that if Dr Chopra is signing a certificate stating there will be an ongoing ‘no change’ for the next five years, it is implicit that it is recorded there is no change.

55. Having had regard to GMP and the evidence from Dr AB and Dr AC, the Tribunal determined that there was a duty on Dr Chopra only to note the relevant clinical findings in the medical record of his assessment of Patient E and that a note to the effect that Patient E’s incapacity was ongoing would have been sufficient. Given that the ‘Certificate of Incapacity’ assessment for the insurance company requires the doctor to certify that a patient will remain occupationally incapacitated
for at least another five years (to age 55 in the case of Patient E) the Tribunal considered that some record of this needed to be set out in the medical records.

56. The Tribunal noted that in not recording anything about the patient’s ongoing incapacity on 3 August 2015, Dr Chopra’s medical note was inadequate.

57. For these reasons the Tribunal finds paragraph 10a of the Allegation proved.

58. It further finds paragraphs 10b, c, d and e of the Allegation not proved.

Allegation 11

11. In not recording the information set out in paragraph 10 above, you failed to record the required clinical details to justify the issuing of Patient E’s ‘Certificate of Incapacity’ dated 6 August 2015. Found not proved.

59. The Tribunal noted that the certificate had been scanned into Patient E’s notes on 6 August 2015. The certificate itself contains details of Patient E’s diagnosis, continuous period of absence from work and his ongoing incapacity to work. Thus, Patient E’s notes contain the required clinical details to justify the issuing of the “Certificate of Incapacity” to work.

60. For this reason it finds paragraph 11 of the Allegation not proved.

Patient F

Allegation 12

12. On 21 July 2015, you consulted with Patient F who had a diagnosis of a massive cellulitis on the left forearm. You failed to:

   a. measure the size of cellulitis; Found proved.

61. The Tribunal had regard to paragraph 15a of GMP, which states:

"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..."
62. The Tribunal then went on to consider Dr Chopra’s note in Patient F’s medical record, in which he stated:

"Problem  Accident caused by plant thorn (First)

Comment  left forearm and arm
Cellulitis of arm massive spreading rapidly over 24 hours there is a 1x2 cms puncture wound on posterior over head of triceps.

Medication  Co-amoxiclav 500mg/125mg tablets Two To Be Taken Three Times A Day 21 tablet

Test Request Blood Diagnostics - Unknown specimen
Test Request: C-reactive protein, blood Request complete
Test Request: Non-Fasting lipid screen, blood Request complete”.

63. In his witness statement Dr Chopra stated:

"51. With regard to allegation 12(a), I do not accept that it represents substandard practice to not record the actual measured size of the cellulitis. I have recorded that it was "massive" and on his left forearm and upper arm and I would aver that this is a sufficient description.”

The Tribunal noted that Dr Chopra maintained the same view in his oral evidence.

64. The Tribunal then considered the opinions of the medical experts on how the above duty is to be fulfilled in the context of this consultation. Dr AB stated in his written report that there was no record of how large the affected area was. He stated that such a record would be vital in assessing subsequent progress. This position was confirmed in his oral testimony where he said some estimate should be made of an objective measurement, a "rough estimate" for a following doctor to assess progress. The Tribunal noted that Dr AB considered there was a duty to sufficiently describe an objective, precise measurement of the cellulitis in the medical notes.

65. In his Expert Report Dr AC stated:

"Dr Chopra has recorded left forearm and arm. It would have been more helpful if he had described how far the cellulitis had spread from the puncture wound which was on the posterior overhead of the triceps. If it had spread down from the whole of the upper arm to the left forearm, this would give a
reasonable description of the area of cellulitis. Many GPs would not actually measure the size but would comment as to the extent. Dr Chopra has recorded left forearm and arm, so it is likely the area of cellulitis had spread from the upper arm to the forearm which does give a description of a massive area of cellulitis.”

66. The Tribunal considered the Joint Expert Report of Dr AB and Dr AC which stated:

“Dr AC will say that Dr Chopra’s use of the word massive indicated that he appropriately recorded the size of the cellulitis.

Dr AB will say that the record needed something more objective to help other clinicians judge any progress at any future consultation.”

67. The Tribunal noted that in his oral evidence, Dr AC conceded that in the context of using the word ‘massive’ in the medical notes, Dr Chopra’s description of the massive cellulitis was unusual and imprecise. When asked during the hearing if it could have been measured, he indicated he had seen doctors physically draw a line on a patient. He admitted that such imprecision was a failing, albeit not significant.

68. The Tribunal found the opinion of Dr AB more convincing on this issue. Whilst the Tribunal noted Dr AC’s view that a patient could always tell a subsequent treating practitioner whether the cellulitis was worse, it did not find on this occasion that such pragmatism was appropriate in relation to a condition which both experts accepted could develop into a more serious condition. The Tribunal accepted therefore Dr AB’s opinion that there was a duty to sufficiently describe an objective measurement of the cellulitis in the medical notes. This was necessary in order to assist any future clinician in identifying if there had been any progress at any subsequent consultation.

69. Having had regard to the matters set out above the Tribunal finds, on balance, paragraph 12a of the Allegation proved.

b. take Patient F’s:

   i. blood pressure; **Found not proved**

   ii. pulse; **Found not proved**

   iii. temperature; **Found not proved**.

70. In his witness statement Dr Chopra stated:

    **MPT: Dr CHOPRA**
"52. With regard to allegation 12(b)(i) – (iii) inclusive, I accept I should have recorded the blood pressure, pulse and temperature, but I maintain that I would have checked these. Accordingly, I deny allegations 12(b)(i) – (iii)."

71. The Tribunal noted that in his oral evidence Dr Chopra stated that although he could not specifically remember due to the passage of time, he was “pretty sure” he had taken Patient F’s blood pressure, pulse and temperature, as was his usual practice. He stated that he would not have recorded them if they were normal, only if they were abnormal.

72. In oral evidence Dr AC stated that he was fully aware that in some cases busy doctors do not always record such results if they are normal, he stated that such an approach was frustrating but acknowledged that there is no evidence in the records that Dr Chopra had taken Patient F’s blood pressure, pulse and temperature.

73. In coming to a conclusion, the Tribunal had regard to Patient F’s overall consultation and had borne in mind that this was a serious presentation by Patient F. It noted that Dr Chopra treated the presenting condition seriously in that he had prescribed antibiotics and requested specific blood tests so was clearly aware of the potential seriousness of the condition.

74. The Tribunal bore in mind the evidence of Dr AC that there may be occasions when a busy General Practitioner takes important observations but only records them if they are abnormal. There was no evidence before the Tribunal to counter Dr AC’s opinion on this.

75. The Tribunal considered that although on this occasion Dr Chopra did not take a careful approach to describing the cellulitis, having regard to the tests he arranged and medication he prescribed for Patient F, the Tribunal considered that this is more consistent with Dr Chopra having conducted the observations.

76. The Tribunal determined, on the balance of probabilities, it finds paragraphs 12b (i) (ii) and (iii) of the Allegation not proved.

    c. record:

    i. the size of cellulitis; Found not proved.

77. In light of the Tribunals findings in relation to paragraph 12a, it determined that Dr Chopra could not record something which he had not done and that therefore he had not failed in a duty to record.

78. The Tribunal therefore finds paragraph 12c (i) of the Allegation not proved.

MPT: Dr CHOPRA
Allegation 13

13. On 3 August 2015, you consulted with Patient F. The records of this consultation were inadequate in that you failed to record details of:

   c. any examination you conducted.

   Found not proved.

79. The Tribunal first considered the medical records which stated:

   "Additional Patient allocated named accountable general practitioner • Informs patient of named accountable general practitioner

   Assessment Alcohol consumption 0 U/week • Never smoked tobacco • British or mixed British - ethnic category 2001 census

   Examination O/E - weight 90 kg • Body mass index 26.9 kg/m2”.

80. The Tribunal noted that it appears Patient F may have attended the consultation for another matter as the record does not refer to the matters set out in the Allegation.

81. In his witness statement Dr Chopra stated:

   "54. On 03.08.15 the blood tests were returned. His serum ferritin was slightly high, but the other results were normal. I had a further consultation with Patient F. I accept that I failed to record that I had reviewed the recent blood tests, although I am quite sure that I did indeed review them. I had downloaded them from the hospital system and would have then reviewed them. I also accept that I did not record any ongoing symptoms. However, I recall that Patient F’s cellulitis had settled on inspection, and that his blood tests were normal. Accordingly, I did not record the points set out at paragraph 13(a) –(c) There was no need to conduct an examination, and no need to record the size of cellulitis, blood pressure, pulse and temperature.”

82. In his Expert Report, Dr AC stated:

   "If the cellulitis had settled, there would be no indication to perform any examination.”

83. In his Expert Report, Dr AB stated:

   "In my opinion, any reasonably competent general practitioner would have
wanted to ask about the ongoing symptoms and then would have examined the arm to see if the cellulitis was receding or increasing or staying the same. Depending on the findings, blood pressure and pulse and temperature may have been appropriately measured.”

84. The Tribunal accepted Dr Chopra’s evidence that on the 3 August 2015, he recalls that Patient F’s cellulitis had ‘settled’ upon his inspection and there was no need for him to conduct an examination.

85. The Tribunal determined that there was no evidence that Dr Chopra carried out an examination in relation to the Patient F’s cellulitis on 3 August 2015, consequently there was no duty for him to make a record of an examination when one did not take place.

86. The Tribunal therefore finds that paragraph 13c of the Allegation not proved.

Patient G

Allegation 14

14. On 5 August 2015, you:

a. consulted with Patient G who you recorded as having a diagnosis of chronic depression. The records of this consultation were inadequate in that you failed to record details of any:

   i. assessment of Patient G’s ongoing symptoms;  
      **Found proved**

   ii. examination you conducted;  
      **Found not proved**.

87. The Tribunal first considered Patient G’s medical record, dated 5 August 2015, which stated:

   "Problem  Chronic depression (Review)"

   *Regime Review*  *Medication review*

   *Follow up*  *Diary Entry Medication review (05-Aug-2016)*

   *Problem  Contraception (Review)*
Medication Co-cyprindiol 2000microgram/35microgram tablets One To Be Taken Each Day As Directed 126 tablet

Comment unable to tolerate micronor. SKIN has broken out into boils. Trial of dianette”.

88. In his witness statement, Dr Chopra stated:

"58. On 05.08.15 Patient G attended an appointment with me. I am sure that this patient’s coding of chronic depression at this appointment represents a coding error, for which I must accept responsibility…”

89. In his oral evidence Dr Chopra accepted that he had caused that entry to be made and in a detailed exposition of the computer record system he conceded that the medical problem would not have been selected from a generic list of problems but would have been selected from a list specific to Patient G.

90. The Tribunal considered that the medical notes show that Patient G first registered with the practice on 10 July 2014. It noted that none of the records go back prior to 7 February 2014. It further noted that none of the records prior to the medical note on the 5 August 2015 referred to chronic depression. However, given Dr Chopra’s evidence on how he would have made the selection, the Tribunal considered that the chronic depression problem must have been in Patient G’s past medical history. Additionally, the Tribunal had close regard to the entry on the 5 August 2015 and noted that Dr Chopra undertook a medication review and also arranged follow up for a further medication review on 5 August 2016, a year hence.

91. In his Expert Report Dr AB stated:

"3.12.1 Did Dr Chopra obtain an adequate medical history?

The medical record noted the problem of chronic depression. If this was the diagnosis then the history obtained as recorded totally failed to mention any features of depression and as such was seriously below the standard expected of a reasonably competent general practitioner. It was seriously below because depression requires a careful assessment which should be recorded for the benefit of any other practitioners who come to treat the patient. If, however, it were believed that "chronic depression" was an inadvertent miscoding then, apart from a criticism of the record, I would have no criticism of the history.

...
3.12.4 Did Dr Chopra make adequate medical records including whether or not the coding was adequate and appropriate?

In my opinion, from the material made available to me concerning the prescription of this pill, the medical records were of a standard below that expected of a reasonably competent general practitioner because of their failure to record appropriate advice given to Patient [G].

If the coding; “chronic depression (review)” is believed to have been erroneous then it would have been below the standard expected but not seriously below because such errors do occur from time to time by inadvertence.

I accept that, if depression was not a true medical problem, the presence of the diagnosis in the records could have caused great inconvenience to Patient [G] in the future when seeking life assurance or travel insurance but, as a one time error for a patient, it is my opinion that it was below rather than seriously below the expected standard.”

And further:

"10.19 Chronic Depression

10.20 It is Dr Chopra’s evidence this was a recording error. The additional records provided by the GMC make no reference to any previous history of depression. It is likely this was a coding error by Dr Chopra.”

92. The Tribunal considered the Joint Expert Report of Dr AB and Dr AC which stated:

"Allegation 14 (a) i and ii:

Dr AC and Dr AB agree that if it is accepted that “chronic depression” was a coding error then this demonstrated record keeping by Dr Chopra which was below the standard expected but would otherwise not be critical.

Otherwise Dr AC and Dr AB would agree that if Patient G was suffering from chronic depression, then the failure to carry out and record a mental health assessment was seriously below an expected standard.”
93. The Tribunal considered that in order for Dr Chopra to make his entries relating to the medication review and follow up, he must have carried out an assessment of Patient G’s symptoms, however cursory. It determined that this cursory assessment was not sufficient to amount to an examination.

94. The Tribunal was unable to accept Dr Chopra’s explanation that the entry onto the medical record of chronic depression was merely an inadvertent coding error. The description he himself gave in his evidence of how he inputted the entry into the medical note indicated to the Tribunal a conscious decision supported by his further setting a reminder supported his having set a subsequent medication review in a year. The Tribunal considered that had Dr Chopra selected chronic medication in error, it was improbable that he would go on to select a twelve month review as this was an additional inputting task on the medical record. The Tribunal therefore did not find the documented evidence to be consistent with a coding error.

95. Given that Dr Chopra had caused a medication review to be set 12 months hence, the Tribunal determined that Dr Chopra would only have done so if he had made an assessment of Patient G, however cursory the assessment. Given the GMP requirements set out above, the lack of any record of this assessment, however brief, amounts to a failure of the duty to record.

96. The Tribunal had regard to the fact that Dr Chopra did not record an examination of Patient G and did not claim to have examined Patient G. The Tribunal concluded that Dr Chopra did not examine Patient G. In those circumstances, the Tribunal determined that there was no duty to record an examination that had not taken place.

97. The Tribunal therefore determined that paragraph 14a (i) of the allegation is proved.

98. It further determined that paragraph 14a (ii) of the Allegation was not proved.

b. prescribed co-cyprindiol 2000/35mg. This prescription was inappropriate in that:

i. an alternative contraception should have been offered; Found not proved

ii. co-cyprindiol is not licensed as a primary contraceptive; Found not proved
iii. it was contrary to the guidance contained in the British National Formulary.

**Found not proved.**

99. The Tribunal noted that Patient G’s notes show that on 24 June 2015 she wanted to restart the oral contraception pill and that she was prescribed six months’ of cilest 250/35 mg tablets.

100. In his witness statement Dr Chopra stated with regard to his prescription on 5 August 2015:

"I deny that the prescription of Co-cyprindiol was inappropriate. Patient G required contraception and was suffering from acne, and I feel that whilst this was not ideal, it was a reasonable prescription. It was not contraindicated for me to prescribe co-cyprindiol despite the fact that it is not licensed as a primary contraceptive."

In his oral evidence Dr Chopra asserted that when he recorded micronor on 5 August 2015, he had in mind a combined oral contraceptive, but mistakenly recorded micronor instead of cilest.

101. The Tribunal went on to consider the Joint Expert Report of Dr AB and Dr AC, which stated:

"If it is accepted that in fact Patient G was not taking micronor but was taking Cilest (a combined oral contraceptive), then Dr AB would be in agreement with Dr AC that many reasonably competent general practitioners would have missed out on using oral antibiotics and would have prescribed co-cyprindiol because of its dual action, Patient G having already tried a combined oral contraceptive with no improvement to her acne."

102. The Tribunal had regard to the medical records of 24 June 2015 referred to above. The Tribunal noted that the experts were clear that if Patient G had been taking cilest, the prescribing of co-cyprindiol on the 5 August 2015 would not have been inappropriate. Since Patient G’s records indicate that she was on cilest, and since the experts are agreed that the prescription issued on the 5 August 2015 was not inappropriate, this sub-paragraph of the Allegation is not proved.

103. The Tribunal therefore finds paragraphs 14b (i) (ii) (iii) of the Allegation not proved.
Patient H

Allegation 15

15. On 5 August 2015, you:

a. consulted with Patient H who had a diagnosis of alcohol dependence syndrome and shingles. The records of this consultation were inadequate in that you failed to record the following details in relation to:

   ii. the shingles outbreak:

      1. its duration; Found proved
      2. its location; Found proved
      3. its extent; Found proved
      4. associated symptoms; Found proved
      5. follow up care. Found proved.

104. The Tribunal had regard to the medical records of Patient H, dated 5 August 2015, which stated:

"Problem  Shingles (First)

Medication  Aciclovir 200mg tablets One To Be Taken Five Times A Day 25 to be kept in reserve 50 tablet”.

105. In his witness statement Dr Chopra stated:

"67. I deny allegations to 15(a)(ii) 1 – 5 as these elements were not required to be recorded for a complaint of cold sore. This was a coding error on my behalf, for which I accept responsibility."

106. The Tribunal also had regard to the Expert Report of Dr AB in which he stated:

MPT: Dr CHOPRA
"3.19.3 Did Dr Chopra keep adequate records for Patient [H] including the reason for attendance?

There are two major problems mentioned. The first is alcohol dependence syndrome which was coded as being the first occurrence although it had been noted previously in October 2014.

As I have noted above, there is no record of the amount of alcohol being taken, any associated mental health issues and there is no record of a treatment plan.

Concerning the shingles, there is no record of the duration of the condition, the extent and location, any associated symptoms and any advice given about when to attend again.

In my opinion, overall, the standard of record-keeping was seriously below that expected of a reasonably competent general practitioner because any clinician treating Patient [H] subsequently would not have known how he was on 5 August 2015, especially regarding his mental state.”

107. The Tribunal noted the medical record which identified the presenting problem as shingles. Although the Tribunal noted Dr Chopra’s position that this was a coding error and that he meant ‘cold sore’, it considered this was not consistent with his account of how he had made the entry. It was Dr Chopra’s evidence that he had entered the problem as shingles as free text rather than a selection from a menu, and as he was typing ‘s.h.i.n’, the entry was completed by predictive text. The Tribunal further noted that notwithstanding that entry Dr Chopra maintained that at no point did he consider the patient had shingles. The Tribunal considered that the detailed account Dr Chopra gave of how to enter a new presenting problem involved a different series of steps than did an existing problem.

108. The Tribunal then considered any additional evidence which would assist its deliberation in relation to Dr Chopra’s contention. On the one hand Mr Colman advanced that it is to Dr Chopra’s credit that he had not sought to shy away from his entry of ‘s.h.i.n.’ to a more simple explanation as to how the error had occurred. On the other hand the Tribunal noted that Dr Chopra went on to prescribe acyclovir orally, a treatment used for shingles and also for a cold sore, only if those cold sores are severe or recurrent. The Tribunal noted there is no evidence in the records of Patient H previously presenting with cold sores. On balance, the Tribunal considered that the actions of Dr Chopra, as he himself had described, and the prescription of oral aciclovir, were consistent with Dr Chopra having in his mind that this was
Patient H’s first presentation with a shingles diagnosis. In accepting the unchallenged recording requirements set out by Dr AB, the Tribunal therefore found Dr Chopra had failed in his recording obligations.

109. The Tribunal therefore finds paragraphs 15a (ii) 1-5 proved.

b. prescribed acyclovir 200mg to be taken five times a day. This prescription was contrary to the guidance contained in the British National Formulary.

**Found proved.**

110. In his witness statement Dr Chopra stated:

"64. ...Patient H was suffering from a cold sore, rather than shingles. He had suffered from cold sores before. For this reason I prescribed acyclovir 200mg five times per day, which was the correct prescription."

111. The Tribunal considered Dr AB’s Expert Report in which he stated:

"3.19.1 Did Dr Chopra appropriately prescribed to Patient [H]?

The prescription was for aciclovir which is an anti-viral drug used for treating among other things shingles which is clinical manifestation of the reactivation of the virus which causes chickenpox (varicella zoster). This consists of painful blisters on the skin in the distribution of nerve roots and can occur at any time in life but mostly in the over 65's.

The dose of aciclovir advised for this condition is set out on page 424 of the BNF (Appendix 11) and it is 800 mg five times daily for seven days."

112. In his Expert Report Dr AC stated:

"...The normal dose to treat shingles is Aciclovir 800mg five times a day, 35 tablets.

11.11 Dr Chopra has prescribed Aciclovir at a dose of 200mg five times a day for five days. This is the dose that is normally prescribed for herpes simplex (cold sores) in adults. It is Dr Chopra’s evidence that this patient suffered from recurrent herpes simplex and he made a mistake by recording this was shingles."
113. The Tribunal accepted the evidence of Dr AB and Dr AC in that this prescription was inappropriate for what Dr Chopra believed was Patient H’s diagnosis, namely shingles. The Tribunal accepted Dr AB’s evidence that this prescription was contrary to the guidance contained in the BNF.

114. The Tribunal therefore finds paragraph 15b of the Allegation proved.

Patient J

Allegation 19

19. On 1 March 2016, you consulted with Patient J’s daughter in Patient J’s absence. This was inadequate in that you failed to assess:

a. Patient J’s condition face to face; Found proved

b. whether Patient J was:
   i. suffering from a pulmonary embolism; Found proved
   ii. seriously ill. Found proved.

115. The Tribunal had regard to Patient J’s medical record that Dr Chopra made on the 1 March 2016 when he saw Patient J’s daughter and to Patient J’s medical records on 8 March 2016 which stated as follows:

1 March 2016

"Problem Foreign travel advice (Review)

Comment has returned from Thailand with a productive cough. Daughter here on her behalf.

Medication Doxycycline 100mg capsules Two To Be Taken On The First Day Then One To Be Taken Each Day 8 capsule

Test Request [Dr Chopra also arranged blood tests]”.

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"Problem  Chesty cough (New)

History  has had a cough since coming back from thailand and has had the cough approx 3 weeks has had 2 courses in Thailand.Still feeling unwell Productive cough -green sputum • Shortness of breath symptom

Examination  Temperature symptoms • O/E - tympanic temperature 37.8 degrees C • O/E - pulse rate 85 beats/min • Oxygen saturation at periphery 92% • O/E – coarse crepitations Laterality: Bilateral • O/E - expiratory wheeze O/E - chest expansion reduced Rt LL

Comment  treat as LRTI most likely Community acquired pneumonia Sputum sent for examination arrange cxr review SOS within 1 week after x-ray.WIC/111 in ooh

Medication  Amoxicillin 500mg capsules 2 to be taken 3 times/day 42 capsule Prednisolone 5mg tablets 6 daily all together for 5 days 30 tablet

Document  Radiology referral I Radiology Form – CODED”.

116. Dr Chopra stated in his witness statement:

"74. On 01.03.16 Patient J’s daughter attended the surgery on her [sic] behalf. She stated that Patient J had returned from Thailand and had a productive cough. I requested blood tests for Patient J and prescribed doxycycline.

75. On 08.03.16 Patient J attended and I examined him. I noted that he had a productive cough since coming back from Thailand, and had had the cough for approximately three weeks. He had undergone two courses of antibiotics in Thailand, and was still feeling unwell.”

76. I noted that he had a productive cough with green sputum, and shortness of breath.

77. I checked his temperature, pulse and O2 saturations and listened to his chest, noting coarse crepitations bilaterally, and an expiratory wheeze. I noted his chest expansion was reduced in the right lower lobe. I decided that this should be treated as LRTI, and most likely community acquired
pneumonia. I sent a sample of the sputum for examination, and arranged a chest x-ray. I safety netted Patient J, asking him to return within one week after the x-ray, and to attend a walk-in clinic, call 111 or attend out of hours if needed. I also prescribed amoxicillin and prednisolone.

78. I deny allegation 19(a). On 01.03.16 I am sure Patient J’s daughter informed me that he had had two courses of antibiotics and I took the view that Patient J should have a further prescription with advice to attend. I note that Patient J attended one week later.”

117. The Tribunal again had regard to paragraph 15a of GMP as set out above.

118. The Tribunal considered the Expert Report of Dr AB which stated:

"3.13.1 Whether Dr Chopra provided adequate and appropriate care and treatment to Patient [J]

It is common practice to prescribe rescue courses of antibiotics and steroids for patients with documented chronic obstructive pulmonary disease who are prone to exacerbations due to infection. In these cases there is a clear written treatment plan with appropriate safety netting.

Patient [J] did not have chronic obstructive pulmonary disease and had the sort of comorbidities including ischaemic heart disease which would have meant that in the event that he started to become unwell with a chesty cough, any reasonably competent general practitioner would want to assess him to see whether the cough was due to infection or heart failure or both and if infection, whether the patient was being made significantly unwell by the infection.

In addition, although less likely, Patient [J] had been on a long plane journey and might have been suffering from a pulmonary embolism. All of this needed a face-to-face assessment.”

And Further:

"When I stated in 3.13.1 that Patient J might have been suffering from a pulmonary embolism, this would have meant that Patient J might have been seriously ill and any reasonably competent general practitioner, in my opinion, should have considered this possibility.”

119. In his Expert Report Dr AC stated:

MPT: Dr CHOPRA
"(a) Patient J's condition face-to-face.

I agree on his record. If the consultation of 8 March is taken into consideration: Patient J had already been prescribed two courses of antibiotics whilst in Thailand, I consider it was reasonable to issue a prescription with the advice to attend. Patient J did attend one week later.

(b) Whether Patient J was:

(i) Suffering from a pulmonary embolism.

On his note, I agree with Dr AB. If you take into consideration the following consultation one week later, it is unlikely that Patient J was suffering from a pulmonary embolism, in particular he had a productive cough and had already received two courses of antibiotics in Thailand. It is more likely than not that he was suffering from a resistant chest infection.

(ii) Seriously ill.

There is no record of whether Patient J was seriously ill. If the consultation of 8 March is taken into consideration, it would suggest that Patient J was not seriously unwell as she was able to attend the following week having been on a further course of antibiotics.”

120. The Tribunal considered the Joint Expert Report of Dr AB and Dr AC which stated:

"Dr AC and Dr AB have not altered their opinions set out in their reports and cannot come to an agreement. Dr AC believes that on the record the actions of Dr Chopra were below the standard expected while Dr AB believes that taking into account the co-morbidities and the recent history of long haul air travel, Dr Chopra's actions were seriously below. What assessment Dr Chopra made on 1 March 2016 is a matter of evidence.”

121. The Tribunal noted the paucity of information concerning Patient J in the record of the consultation with his daughter on 1 March 2016 and that the medical problem is labelled as 'foreign travel advice'. Dr Chopra in his written and oral evidence maintained that Patient J’s daughter had made him aware on 1 March 2016 of her father having been prescribed courses of antibiotics in Thailand. The Tribunal contrasted this entry with the comprehensive level of detail recorded when Dr Chopra saw Patient J face to face on 8 March 2016, where reference to the
prescription of two courses of antibiotics is recorded for the first time. The Tribunal finds that had Patient J’s daughter provided this information on 1 March 2016, Dr Chopra would have recorded it on that day as justification for not seeing Patient J face to face.

122. The Tribunal considered Dr AB’s opinion in which he says that given Patient J’s age and co-morbidities which included ischaemic heart disease, leg swelling and a suspicion of DVT, and the fact that Patient J’s daughter had informed Dr Chopra that Patient J had just returned from Thailand on a long haul flight. Dr Chopra needed to assess Patient J face to face as there was a real risk of pulmonary embolism or other serious illness which Dr Chopra needed to exclude.

123. The Tribunal noted that on 1 March 2016 Dr Chopra did order blood tests which were taken on 7 March 2016, even though he had not seen Patient J face to face, demonstrating that he was concerned about Patient J’s clinical condition.

124. The Tribunal considered that Patient J’s co-morbidities, age and long haul flight were indicators for Dr Chopra to see him face to face. The fact that Dr Chopra arranged blood tests highlights his concern as to the patient’s condition and is a further indicator for him to see the patient face to face. Given the Tribunal’s finding above that Dr Chopra had not been aware on 1 March 2016 of Patient J having been prescribed courses of antibiotics in Thailand, he was under a duty to assess Patient J’s condition face to face and to assess whether Patient J might have been suffering from a pulmonary embolism or was seriously ill.

125. The Tribunal therefore finds paragraph 19a and b (i) and (i) of the Allegation proved.

Patient M

Allegation 27

27. On 11 April 2016, you consulted with Patient M and you failed to:

a. arrange a face to face consultation with Patient M;  
   **Found proved**

b. properly assess Patient M;  
   **Found proved**.

126. The Tribunal had regard to the medical record for Patient M on 10 March 2016, 18 March 2016 and 11 April 2016 respectively, which stated:
10 March 2016

"Problem  Chest infection NOS (Review)

Medication  Candesartan 4mg tablets One To Be Taken Each Day 28 tablet

Test Request  Blood Diagnostics - Unknown specimen
  Test Request: Full blood count - FBC Request complete
  Test Request: Ferritin, blood Request complete
  Microbiology - Unknown specimen
  Test Request: Urine Culture(HAST) Request complete

Examination  Slight cough for past few days, no fever and non-productive. Chest clear, declined medication. Will try otc remedies. Rv if sx increase.
  Blood sample taken
  O/E - blood pressure reading 151/76 mmHg several high readings at home recently so recommence candesartan. Recheck 1/12...."

18 March 2016

"Problem  Bronchiectasis (Review)

History  she has had a cough and initially did not want antibiotics. However became worse. She has had doxycycline at home which she took and has been feeling better but excessively tired explained the BT wcc raised. May need to be repeated. Advised to have BT asap.

Test Request  Blood Diagnostics - Unknown specimen
  Test Request: C-reactive protein, blood Request complete
  Test Request: Full blood count - FBC Request complete
  Test Request: Ferritin, blood Request complete

Examination  O/E - blood pressure reading 144/74 mmHg not keen on increasing her Medications, compliance issues discussed ..........with patient.”

11 April 2016

MPT: Dr CHOPRA
"Problem  Acute respiratory infection NOS (Review)
Regime Review  she is in bed with a chest infection. Unable to
Follow up  Doxycycline 100mg capsules Two To Be Taken On The
First Day Then One To Be Taken Each Day 8 capsule”.

127. In his witness statement Dr Chopra stated:

"89. I deny allegation 27(a) relating to Patient M. I disagree that
there was strictly a need to arrange a face-to-face consultation with
Patient M, given that she had a history of repeated chest infections,
and that when I had seen her on 18.03.16 I had offered her antibiotics
due to an increased white blood cell count, which she had declined. I
felt that in these circumstances it was reasonable for me to prescribe
the patient with antibiotics on 11.04.16.

90. I am unsure as to what assessment it is alleged I should have
performed at allegation 27(b)."

128. The Tribunal considered the Expert Report of Dr AB which stated:

"3.5.1 Whether Dr Chopra provided adequate and appropriate care and
treatment to Patient [M]?

In my opinion on 11 April 2016, especially in view of the past history of
Patient [M] and her age, any reasonably competent general practitioner would
have arranged a face-to-face consultation.

There also was no record of any safety netting.

In my opinion the failure of Dr Chopra to properly assess and safety net
Patient [M] demonstrated a standard of care seriously below that expected of
a reasonably competent general practitioner.”

129. The Tribunal considered the Expert Report of Dr AC who stated:

"16.16 Patient M was diagnosed with recurrent chest infections and
bronchiectasis. She had mentioned a cough when she had been seen by Dr
Chopra on 18 March when she did not want antibiotics and he organised
blood tests. This was appropriate.
16.17 11 April 2016

16.18 Dr Chopra spoke to this patient. She was in bed unable to be seen and was requesting antibiotics. Dr Chopra knew that she had bronchiectasis and was at risk of recurrent chest infections. She declined the offer of antibiotics on 18 March. In my opinion it was reasonable to prescribe antibiotics...”

130. The Tribunal considered that Dr AC’s opinion relies on an inaccurate interpretation of the consultation on 18 March 2016. The Tribunal finds that Patient M was neither offered nor declined antibiotics on 18 March 2016. It considered that the medical notes do not support this assertion. The Tribunal was not satisfied, on the balance of probabilities, that Patient M refused antibiotics on 18 March 2016. Therefore Dr AC’s opinion was based on a false premise.

131. The Tribunal determined that there is no evidence on the face of the records that Patient M was either offered or refused a face to face consultation.

132. The Tribunal noted that the medical records contain no reference to an assessment of Patient M and it is common ground between the parties that he did not arrange a face to face consultation with her in order to assess her.

133. Given that Dr AC’s evidence was based on an incorrect factual assumption, the Tribunal preferred Dr AB’s that given Patient M’s past history, age, overall vulnerability and what her presenting complaint was over the telephone, that there was a duty on Dr Chopra to arrange a face to face consultation. The Tribunal determined that Dr Chopra failed to arrange a face to face consultation and to assess Patient M on 11 April 2016.

134. The Tribunal therefore finds paragraph 27a and b of the Allegation proved.
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c. provide appropriate warnings about what further symptoms should cause Patient N to seek urgent hospital attention. **Found not proved.**

135. The Tribunal had regard to Dr Chopra’s medical note of the telephone consultation on 11 April 2016, which stated:

"Problem Accidental falls (First)
Comment fell from her car on the floor.Has a bump.No concussion.Reassured."

136. In his witness statement Dr Chopra stated:

"94. I deny allegation 28(c). I am confident that I would have provided appropriate warnings and advice as standard."

137. The Tribunal considered the Expert Report of Dr AB who observed that Dr Chopra should have:

"...provide[d] appropriate warnings, preferably written, about what future symptoms should cause Patient [N] to seek urgent hospital attention in the next few days. Dr Chopra did not do this."

138. In his Expert Report Dr AC stated:

"17.12 Dr Chopra has made a brief note that she fell from her car onto the floor. It is not clear why she fell from the car. She sustained a bump, it is not clear where this bump was to (presumably her head). Dr Chopra has recorded this patient had no concussion. Dr Chopra must have asked some questions to be able to record this. He gave reassurance.

...it would have been appropriate to give reassurance and give advice of what symptoms to look out for."

139. The Tribunal had regard to Dr Chopra’s admitted failures in relation to this telephone consultation, failures that not only were basic but were directly related to the safety of the patient. It is Dr Chopra’s case that although he does not specifically remember providing appropriate warnings, he was confident he would have provided them as this was his standard practice. However, in the absence of any further evidence and taking account of the principle mentioned earlier that the lack of an entry in the medical records does not prove that something had not been done, the Tribunal was not satisfied that the GMC had discharged the burden of proof.
140. The Tribunal therefore finds paragraph 28c of the Allegation not proved.

Patient P

**Allegation 31**

31. On 26 April 2016, you:
   
a. consulted with Patient P. The records of that consultation were inadequate in that you failed to record:
   
   iii. any examination undertaken; **Found not proved**.

141. The Tribunal was mindful that Dr Chopra had admitted paragraph 31b (i) 1 of the Allegation at the outset of the hearing. In those circumstances the Tribunal determined that since there was no examination to record, Dr Chopra had no reason or obligation to record one.

142. The Tribunal therefore finds paragraph 31a (iii) of the Allegation not proved.

**Allegation 32**

32. On 22 June 2016, you:
   
a. consulted with Patient P. The records of that consultation were inadequate in that you failed to record:
   
   iii. any examination undertaken; **Found not proved**.

143. The Tribunal was mindful that Dr Chopra had admitted paragraph 32b (i) 1 of the Allegation at the outset of the hearing. In those circumstances the Tribunal determined that since there was no examination to record, Dr Chopra had no reason or obligation to record one.

144. The Tribunal therefore finds paragraph 32a (iii) of the Allegation not proved.

Patient Q

**Allegation 33**

33. On 2 March 2016, you consulted with Patient Q during which you prescribed candesartan 16mg and indapamide 2.5mg. This prescription was inappropriate in that:
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a. it exceeded the usual starting dose of candesartan;
Found proved

b. the combination of the two drugs placed Patient Q at risk of low blood pressure and attendant falls. Found proved.

145. In his witness statement, Dr Chopra stated:

"106. With regard to allegation 33, I disagree with this allegation on the basis that I was aware of Patient Q’s recent admission to hospital with significantly raised blood pressure. I feel the dose was reasonable in those circumstances. I also feel that there is no evidence that Patient Q was at risk of low blood pressure and falls, and I monitored her closely thereafter."

146. In his Expert Report, Dr AA stated:

"...Dr Chopra changed Patient [Q]’s medication to indapamide 2.5 mg (a diuretic) and candesartan 16mg (an ARB). In my opinion Patient [Q]’s blood pressure was not seriously raised for a 78 year old. Whilst, in my opinion, it was appropriate to change medication because of side effects, Dr Chopra prescribed excessive medication. In my opinion, a reasonably competent GP would have stopped amlodipine and simply given indapamide on its own, given Patient [Q]’s age. Dr Chopra gave candesartan 16mg which is above the usual starting dose of candesartan of 4mg. Giving this dose put Patient [Q] at risk of a significant drop in blood pressure with possible consequences such as falls. Dr Chopra did arrange review and for bloods to be taken.”

147. In his Expert Report Dr AC considered that the choice of dose of Candesartan "was within range of General Practitioners” and that the combination of the two drugs was appropriate.

148. The Tribunal noted that both Dr AA and Dr AC agreed that Dr Chopra’s prescription of Candesartan exceeded the usual starting dose of either 4 mg or 8 mg. However, it noted Dr AA’s evidence that this prescription of the higher dose of Candesartan put Patient Q at extra risk.

149. The Tribunal noted that although Dr AC asserted that the 16mg of Candesartan was not inappropriate and was within a range of reasonable practitioners, it noted his concession that 16 mg was outside of the NICE guidelines and that it would have been safer to prescribe a lower dose.
150. The Tribunal took into account that Patient Q historically had a reasonably low blood pressure for her age. However, it noted that she had an extremely high blood pressure on her admission to hospital. Both experts were in agreement that indapamide would decrease the blood pressure further which would increase the patient’s risk of low blood pressure and attendant risk of falls.

151. Given Patient Q’s medical history, the NICE guidelines and the BNF’s guidance, the Tribunal was persuaded by Dr AA’s opinion that a careful stepwise progression was required and there was no justification for exceeding the usual starting dose of Candesartan by at least 100%, the addition of the indapamide and the placing of Patient Q at increased risk of low blood pressure and the attendant risk of falls.

152. The Tribunal therefore finds paragraphs 33a and b of the Allegation proved.

**Allegation 35**

35. At each of the consultations referred to at paragraph 34 you:

a. failed to review Patient Q’s blood pressure medication appropriately; **Found not proved**

b. placed Patient Q at risk of low blood pressure and attendant falls. **Found not proved**.

153. The Tribunal noted that in their initial reports Dr AA and Dr AC were not in agreement. However, in their later Joint Expert Report, they stated:

"Allegation 35 (a):

Dr AA and Dr AC are agreed Dr Chopra reviewed Patient Q on 24 March 2016, 5 April 2016 and 27 April 2016. We are agreed this was a reasonable time frame to monitor and review Patient Q.

Dr AA and Dr AC are agreed Dr Chopra reviewed Patient Q’s medication appropriately.

Allegation 35 (b):

Dr AA states Patient Q was at risk of low blood pressure and attendant falls. Dr AA notes Dr Chopra did monitor Patient Q closely. In this particular case, Dr AA accepts Patient Q was not at risk of low blood pressure and attendant falls in view of Dr Chopra’s careful monitoring."
Dr AC maintains the view expressed in his report.”

154. The Tribunal noted both experts consider that Patient Q’s blood pressure was monitored on 24 March 2016, 5 April 2016 and 27 April 2016 and neither criticised Dr Chopra’s review of the blood pressure medication.

155. The Tribunal accepted the expert opinion of Dr AA, in which he confirmed that on the relevant dates of 24 March 2016, 5 April 2016 and 27 April 2016, the risk to Patient Q of having low blood pressure and attendant falls was mitigated by the close monitoring in place.

156. The Tribunal therefore finds paragraphs 35a and b of the Allegation not proved.

The Tribunal’s Overall Determination on the Facts

157. The Tribunal has determined the facts as follows:

Patient A

1. On the dates in Schedule 1, you gave Patient A iron injections for anaemia. This was inappropriate in that you had not:

   a. established the cause of the anaemia;
      Admitted and found proved

   b. attempted oral iron as a first line treatment.
      Admitted and found proved

2. On 3 August 2015, you consulted with Patient A who had a diagnosis of constipation. The records of this consultation were inadequate in that you failed to record:

   a. a history of the symptoms including:
      i. duration; Admitted and found proved
      ii. frequency of bowel action; Admitted and found proved
      iii. description of stool; Admitted and found proved
      iv. presence or absence of blood; Admitted and found proved
      v. any weight loss; Admitted and found proved
vi. diet; **Admitted and found proved**

vii. fluid intake; **Admitted and found proved**

b. any advice given regarding:

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

ii. laxative medication. **Admitted and found proved**

3. You prescribed oramorph 10mg/5ml oral solution up to four times per day as needed. This prescription was inappropriate in that oramorph can cause or worsen constipation. **Admitted and found proved**

4. Your referral to the gastroenterologist was not sufficient in that you failed to:

a. inform the specialist of Patient A’s medication history; **Found not proved**

b. update your referral following your consultations with Patient A on:

i. 30 July 2015 with regard to Patient A suffering severe constipation due to the codeine; **Found not proved**

ii. 3 August 2015 with regard to prescribing Patient A oramorph. **Found not proved**

**Patient B**

5. On 11 May 2012, you consulted with Patient B who had a diagnosis of hiatus hernia and had severe reflux. You prescribed pantoprazole 40mg twice a day, but you failed to arrange for appropriate reviews of this medication to take place. **Admitted and found proved**

6. On 28 April 2014, you consulted with Patient B and you prescribed esomeprazole 40mg twice daily. This prescription was contrary to the guidance contained in the British National Formulary. **Admitted and found proved**

7. On 3 August 2015, you consulted with Patient B and you prescribed a trial of domperidone 10mg tablet to be taken twice a day. This prescription was contrary to the guidance contained in the British National Formulary. **Admitted and found proved**
Patient C

8. On 3 August 2015, you:
   a. consulted with Patient C who had a new problem of solar keratosis. The records of this consultation were inadequate in that you failed to record:
      i. the location and size of the solar keratosis; Admitted and found proved
      ii. any advice given to Patient C; Admitted and found proved
      iii. any follow up plan you made; Admitted and found proved
   b. prescribed dovobet gel 60g. This prescription was inappropriate in that:
      i. dovobet gel is indicated for plaque psoriasis not solar keratosis; Admitted and found proved
      ii. the amount prescribed was excessive. Admitted and found proved

Patient D

9. On 3 August 2015, you consulted with Patient D who had a diagnosis of diarrhoea with cryptosporidium microscopy. The records of this consultation were inadequate in that you failed to record any advice you had given to Patient D about:
   a. handwashing; Admitted and found proved
   b. cooking; Admitted and found proved
   c. occupational risk. Admitted and found proved

Patient E

10. On 3 August 2015, you consulted with Patient E who had a diagnosis of severe cervical cord compression. The records of this consultation were inadequate in that you failed to record details of:
    a. ongoing incapacity; Found proved
    b. current symptoms; Found not proved
c. mobility; **Found not proved**

d. use of painkillers; **Found not proved**

e. actions precipitating pain (if any). **Found not proved**

11. In not recording the information set out in paragraph 10 above, you failed to record the required clinical details to justify the issuing of Patient E’s ‘Certificate of Incapacity’ dated 6 August 2015. **Found not proved**

**Patient F**

12. On 21 July 2015, you consulted with Patient F who had a diagnosis of a massive cellulitis on the left forearm. You failed to:

   a. measure the size of cellulitis; **Found proved**

   b. take Patient F’s:

      i. blood pressure; **Found not proved**

      ii. pulse; **Found not proved**

      iii. temperature; **Found not proved**

   c. record:

      i. the size of cellulitis; **Found not proved**

      ii. blood pressure; **Admitted and found proved**

      iii. pulse; **Admitted and found proved**

      iv. temperature. **Admitted and found proved**

13. On 3 August 2015, you consulted with Patient F. The records of this consultation were inadequate in that you failed to record details of:

   a. your review of recent blood tests; **Admitted and found proved**
b. ongoing symptoms;
   Admitted and found proved

c. any examination you conducted.
   Found not proved

Patient G

14. On 5 August 2015, you:

   a. consulted with Patient G who you recorded as having a diagnosis of chronic depression. The records of this consultation were inadequate in that you failed to record details of any:

      i. assessment of Patient G’s ongoing symptoms;
         Found proved

      ii. examination you conducted;
         Found not proved

   b. prescribed co-cyprindiol 2000/35mg. This prescription was inappropriate in that:

      i. an alternative contraception should have been offered;
         Found not proved

      ii. co-cyprindiol is not licensed as a primary contraceptive;
         Found not proved

      iii. it was contrary to the guidance contained in the British National Formulary.
         Found not proved

Patient H

15. On 5 August 2015, you:

   a. consulted with Patient H who had a diagnosis of alcohol dependence syndrome and shingles. The records of this consultation were inadequate in that you failed to record the following details in relation to:

      i. alcohol dependence syndrome:

         1. any assessment of Patient H’s psychological symptoms;
            Admitted and found proved
2. alcohol intake; **Admitted and found proved**

3. a treatment plan; **Admitted and found proved**

4. follow up care; **Admitted and found proved**

   ii. the shingles outbreak:

   1. its duration; **Found proved**
   2. its location; **Found proved**
   3. its extent; **Found proved**
   4. associated symptoms; **Found proved**
   5. follow up care; **Found proved**

b. prescribed acyclovir 200mg to be taken five times a day. This prescription was contrary to the guidance contained in the British National Formulary. **Found proved**

**Patient I**


17. On 5 August 2015, you consulted with Patient I. You:

   a. prescribed Patient I losartan; **Admitted and found proved**

   b. failed to record details of the exact nature of Patient I’s adverse reaction to perindopril. **Admitted and found proved**

18. The prescriptions at paragraphs 16 and 17(a) were inappropriate in that neither medication was clinically indicated. **Admitted and found proved**

**Patient J**

19. On 1 March 2016, you consulted with Patient J’s daughter in Patient J’s absence. This was inadequate in that you failed to assess:
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a. Patient J’s condition face to face; **Found proved**

b. whether Patient J was:
   
   i. suffering from a pulmonary embolism; **Found proved**
   
   ii. seriously ill. **Found proved**

20. The record of your consultation with Patient J’s daughter, referred to at paragraph 19, was inadequate in that you failed to record:

   a. a history; **Admitted and found proved**

   b. advice about when Patient J should attend for a further assessment; **Admitted and found proved**

   c. what warning signs Patient J should look for that would indicate the need for urgent reassessment. **Admitted and found proved**

**Patient K**

21. On 11 November 2015, you consulted with Patient K during which you prescribed losartan 50mg. The records of this consultation were inadequate in that you:

   a. recorded this as a first consultation for hypertension, when the patient had been attending at the practice for management of his blood pressure since September 2013; **Admitted and found proved**

   b. failed to record;

   i. that the patient was doing home readings to monitor his blood pressure; **Admitted and found proved**

   ii. what the home readings were. **Admitted and found proved**
22. On 15 January 2016, you consulted with Patient K and changed the prescription to candesartan 32 mg. This prescription was inappropriate in that:
   a. the losartan should have been increased to 100mg instead;  
   **Admitted and found proved**
   b. the dose of candesartan was too high. **Admitted and found proved**

23. On 2 February 2016, you consulted with Patient K and you reduced the dose of candesartan to 16mg, which was an insufficient reduction. **Withdrawn**

24. On 4 March 2016, you consulted with Patient K. Patient K’s blood pressure reading was 121/66. You:
   a. failed to reconsider the original diagnosis of essential hypertension;  
   **Withdrawn**
   b. failed to consider stopping all treatment;  
   **Withdrawn**
   c. placed Patient K at risk of having too low a blood pressure. **Withdrawn**

**Patient L**

25. On 25 November 2015, Patient L had a HbA1C blood test. Following receipt of the blood test result you failed to:
   a. code the test results correctly in the records;  
   **Admitted and found proved**
   b. diagnose Patient L with diabetes;  
   **Admitted and found proved**
   c. treat Patient L for diabetes. **Admitted and found proved**

26. In March 2016, Patient L had a glucose tolerance test the result of which you failed to code correctly. **Admitted and found proved**

**Patient M**

27. On 11 April 2016, you consulted with Patient M and you failed to:
   a. arrange a face to face consultation with Patient M; **Found proved**
b. properly assess Patient M; **Found proved**
c. record any safety netting. **Admitted and found proved**

**Patient N**

28. On 11 April 2016, you consulted with Patient N by telephone and you failed to:

a. take a sufficiently detailed history so as to assess the:
   
i. reason for the fall; **Admitted and found proved**
   
ii. the adverse effects from the fall; **Admitted and found proved**

b. arrange for a face to face consultation in order to exclude:
   
i. any significant head injury; **Admitted and found proved**
   
ii. a faint associated with the medication for hypertension; **Admitted and found proved**
   
iii. a seizure; **Admitted and found proved**
   
iv. an assault, given Patient N’s history of domestic violence; **Admitted and found proved**

   c. provide appropriate warnings about what further symptoms should cause Patient N to seek urgent hospital attention. 
   **Found not proved**

**Patient O**

29. On 27 April 2016, you consulted with Patient O during which you prescribed losartan 50mg. This prescription was inappropriate in that you:

a. prescribed a dose that was too high for a person of Patient O’s age; **Admitted and found proved**

b. exposed Patient O to the risk of sudden drop in blood pressure and attendant falls. **Admitted and found proved**

30. The record of your consultation referred to at paragraph 29 was inadequate in that it was not clear whether Patient O was already taking losartan or whether you had initiated this. **Admitted and found proved**
Patient P

31. On 26 April 2016, you:
   
a. consulted with Patient P. The records of that consultation were inadequate in that you failed to record: **Admitted and found proved**
   
i. an adequate history regarding urinary problems such as whether Patient P had:
      
      1. pain on passing urine; **Admitted and found proved**
      2. problems with his urine stream; **Admitted and found proved**
   
ii. the duration of the symptoms; **Admitted and found proved**

iii. any examination undertaken; **Found not proved**

b. failed to:
   
i. conduct a proper assessment of Patient P in that you did not:
      
      1. examine Patient P; **Admitted and found proved**
      2. take a comprehensive history; **Admitted and found proved**
   
ii. check Patient P’s PSA results and/or arrange for a further test; **Admitted and found proved**

iii. put yourself in a position to:
      
      1. formulate a treatment plan; **Admitted and found proved**
      2. enable a definitive diagnosis to be made. **Admitted and found proved**

32. On 22 June 2016, you:

   a. consulted with Patient P. The records of that consultation were inadequate in that you failed to record:
      
      i. an adequate history regarding urinary problems such as whether Patient P had:
      
      1. pain on passing urine; **Admitted and found proved**

2. problems with his urine stream; Admitted and found proved
ii. the duration of the symptoms; Admitted and found proved
iii. any examination undertaken; Found not proved

b. failed to:
   i. conduct a proper assessment of Patient P in that you did not:
      1. examine Patient P; Admitted and found proved
      2. take a comprehensive history; Admitted and found proved
   ii. arrange a PSA test for Patient P; Admitted and found proved
   iii. put yourself in a position to:
      1. formulate a treatment plan; Admitted and found proved
      2. enable a definitive diagnosis to be made. Admitted and found proved

Patient Q

33. On 2 March 2016, you consulted with Patient Q during which you prescribed candesartan 16mg and indapamide 2.5mg. This prescription was inappropriate in that:
   a. it exceeded the usual starting dose of candesartan; Found proved
   b. the combination of the two drugs placed Patient Q at risk of low blood pressure and attendant falls. Found proved

34. You had further consultations with Patient Q on:
   a. 24 March 2016; Admitted and found proved
   b. 5 April 2016; Admitted and found proved
   c. 27 April 2016. Admitted and found proved

35. At each of the consultations referred to at paragraph 34 you:
a. failed to review Patient Q’s blood pressure medication appropriately; 
   **Found not proved**

b. placed Patient Q at risk of low blood pressure and attendant falls.  
   **Found not proved**

**Patient R**

36. You consulted with Patient R on the following dates:

   a. 6 July 2015; **Admitted and found proved**
   
   b. 2 February 2016; **Admitted and found proved**
   
   c. 28 June 2016. **Admitted and found proved**

37. At each of the consultations set out in paragraph 36, you prescribed aciclovir for the treatment of shingles, the details of which are set out at Schedule 2. **Admitted and found proved**

38. The prescriptions as detailed in Schedule 2 were inappropriate in that you:

   a. did not prescribe the correct dose in line with the British National Formulary; **Admitted and found proved**
   
   b. put Patient R at:

      i. risk of incomplete and inadequate treatment;  
         **Admitted and found proved**

      ii. increased risk of post herpetic neuralgia.  
         **Admitted and found proved**

**Patient S**

39. On 7 February 2017, you consulted with Patient S during which you prescribed metformin 1.5g twice a day. This prescription was inappropriate in that you:

   a. exceeded the maximum dose as set out in the British National Formulary; **Admitted and found proved**

   b. exposed Patient S to the risk of significant and potentially dangerous side effects. **Admitted and found proved**
Ms T

40. On an unknown date between 12 February 2016 and 24 August 2016, you asked Mrs T to make an audit sheet with various dates in 2014 and 2015 written on it. The audit trail produced indicated that Mrs T had:

a. checked the medical bag, when she had not; Withdrawn

b. updated the items in the medical bag, when she had not. Withdrawn

41. The audit trail thereby produced was false. Withdrawn

42. On 23 August 2016, in relation to an emergency drug bag that was not returned on 21 October 2015, you said to Ms T “So, can we say you were here on this day?”, or words to that effect. Withdrawn

43. Your actions at paragraph 41 and 43 above were dishonest as you knew Ms T:

a. was not an employee until 2016; Withdrawn

b. could not have carried out the tasks in 2014 and 2015. Withdrawn

And that by reason of the matters set out above your fitness to practise is impaired because of your:

a. deficient professional performance in respect of paragraphs 1-39; To be determined

b. misconduct in respect of paragraphs 40-43. Withdrawn

Determination on Impairment - 23/04/2019

1. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts found proved, Dr Chopra’s fitness to practise is impaired by reason of deficient professional performance.

The Evidence

2. 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.
Record of Determinations –
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3. On behalf of the GMC:
   - XXX

4. On Dr Chopra’s behalf:
   - A course registration confirmation for 26 June 2019 at the Royal College of General Practitioners’ – Telephone Consultations and Triage Skills Training;
   - Correspondence between the GMC and a number of patients who were the subject of the matters before the Tribunal;
   - Testimonial letters;
   - Reports from Dr Chopra’s current and former Clinical Supervisors;
   - Reports from Dr Chopra’s Educational Supervisor;
   - Continuous Professional Development (‘CPD’) certificates;
   - Reflective writing.

Submissions on behalf of the GMC

5. In summary, Ms Duckworth submitted that there was clear and overwhelming evidence in support of a finding of deficient professional performance. Ms Duckworth acknowledged that since the GMC investigation began Dr Chopra has undertaken a considerable amount of CPD and remediation to address his failings in practice so when the Tribunal are determining the issue of fitness to practise, it will be looking at the issue of impairment as of today.

6. Ms Duckworth invited the Tribunal to consider all the facts of this case, those admitted and found proved and those found proved. She submitted that the first issue to be addressed by the Tribunal is whether it was satisfied that there was deficient professional performance.

7. Ms Duckworth referred the Tribunal to the relevant paragraphs of GMP. She submitted that most doctors measure up to the high standards as set out in GMP but that a small number fell seriously short and thereby put patients at risk, cause them serious harm or distress, or undermine public confidence in doctors generally. She submitted that for this reason, the GMC has legal powers to take action where it appears that a doctor’s fitness to practise may be affected by performance. She submitted that the role of the GMC and then MPTS was not to punish practitioners but to fulfil the statutory overarching objective.
8. Ms Duckworth referred the Tribunal to each of Dr Chopra’s failings patient by patient and identified where the GMC says Dr Chopra’s performance was seriously below the standard required.

9. Ms Duckworth submitted that the most serious aspect of charges 31 and 32 in relation to Patient P were admitted. She submitted that the Tribunal will have regard to the particular level of remorse expressed to this patient and his family because of the significance in the context of the patient’s eventual diagnosis of terminal cancer. Ms Duckworth submitted that it was not suggested that Dr Chopra was solely responsible for this, but that a significant opportunity to detect the condition was missed. She submitted that the impact of this failure upon Patient P and his family cannot be ignored or underestimated.

10. Ms Duckworth submitted that the care given to Patient P by Dr Chopra on 26 April 2016 and 22 June 2016 was deficient because Dr Chopra did not complete an adequate examination of the patient, did not complete adequate notes, and did not check Prostate Specific Antigen ('PSA') test results. She submitted that the PSA test had been ordered but for some reason had not been carried out and that Dr Chopra’s failure to check the results and arrange for a further test was a missed opportunity to enable a definitive diagnosis to be made and identify that the patient was suffering from prostate cancer. Ms Duckworth submitted that the GMC says that the standard of care given to Patient P fell seriously below the expected standard because the failures led to a delayed diagnosis of a serious condition.

11. Ms Duckworth submitted that the Tribunal may take the view that the deficient professional performance in relation to the care of Patient P was of particular relevance to its determination of whether the failings by Dr Chopra in the exercise of his professional duties had the effect of eroding public confidence in the profession when it comes time to consider the issue of current impairment.

12. Ms Duckworth invited the Tribunal to consider the relevant legal principles, namely those set out in Calhaem v GMC [2007] EWHC 2606 (Admin). In relation to current impairment, Ms Duckworth referred the Tribunal to the legal principles set out in Grant v Nursing and Midwifery Council [2011] EWHC 927 (Admin).

13. Ms Duckworth acknowledged how impressive Dr Chopra’s efforts at remediation have been and that he has shown a great deal of insight into his deficient performance. She submitted that it should be recognised that Dr Chopra has made changes to the way in which he practices. She submitted that the Tribunal was aware that Dr Chopra had been XXX for some time. Ms Duckworth submitted that they, together with the insight Dr Chopra has shown, have assisted him to
remediate some of his deficiencies but that this does not suggest his fitness to practise is no longer impaired.

14. Ms Duckworth submitted that whilst Dr Chopra’s insight was well developed, it was not fully developed. She submitted that Dr Chopra had demonstrated acceptance of responsibility, but not a full understanding over where he went wrong in the past. She submitted that there remains a risk of repetition but conceded that the steps taken by Dr Chopra to remediate before these proceedings today have already reduced the risk.

15. Ms Duckworth submitted that the fact that, Dr Chopra is prepared to enrol on a further course is impressive but is also acknowledgement that there remains areas for improvement. She submitted that a finding of impairment is important in this case both to protect patients from future risk but also to uphold proper professional standards and public confidence in the profession.

Submissions on behalf of Dr Chopra

16. In summary, Mr Colman submitted that the issue of whether admitted failings were below or seriously below the expected standard was one on which the Tribunal has the expert evidence on both sides. He submitted that the defence adopt the Tribunal’s finding that Dr AC “tended towards a more pragmatic approach, more relevant and consistent with the pressures and realities of busy general practice” than did Dr AB and suggests that the Tribunal should prefer Dr AC’s view where there was a difference of opinion.

17. Mr Colman submitted that the defence concedes that Dr Chopra’s professional performance had been shown to be unacceptably low by reference to a fair sample of his work, however he submitted that Dr Chopra’s patients were highly appreciative of his care including some of those who were the subject of the Allegations before the Tribunal.

18. Mr Colman submitted that it was a novel feature of this case that such patients have stressed how much they thought of the doctor under investigation: “a wonderful GP who was missed”, “a godsend”, “phenomenal and only wish he was still about”, “superb”, “a lovely doctor, caring and considerate and not one who ever rushed you out.”

19. Mr Colman submitted that the Tribunal also had before it a large number of more conventionally obtained testimonials from patients who clearly considered Dr Chopra to be an exceptional doctor. He submitted that the Tribunal may have seen many testimonials in this forum but the theme that comes across repeatedly from Dr
Chopra’s patients was not just the respect that they have for Dr Chopra’s professional skills, but their personal attachment to Dr Chopra because of the care he has shown them.

20. Mr Colman submitted that patients are not experts in medicine and may be mistaken about the details of clinical treatment but that there was more to medical care than the clinical, and public confidence in the profession was also upheld by the standard of personal care that Dr Chopra provided, that aspect of doctoring about which patients cannot be mistaken. He submitted that Dr Chopra’s devotion to the medical profession and to his patients shines through the testimonials put before the Tribunal.

21. Mr Colman submitted that the Tribunal then had the testimonials from professional colleagues: General Practitioners he has worked with; consultants he has referred to and staff at Harold Road Surgery where he has worked since these allegations arose. He submitted that professionals are better able to speak about Dr Chopra’s clinical abilities and they describe a dedicated and capable doctor.

22. Mr Colman submitted that this investigation had been considerably protracted and Dr Chopra’s practice has been restricted XXX preventing sole practice and requiring supervision for over three years. He submitted that the result of this situation was that the Tribunal had available to it the sort of material that Tribunals only usually receive on a review hearing, after a period of substantive sanction. He submitted that the Tribunal had the reports of his Clinical Supervisors and those of his Educational Supervisor. Mr Colman submitted that the upshot was that Dr Chopra has engaged so completely with remediation and worked so assiduously at it that his Clinical Supervisors and Educational Supervisor had effectively run out of things to do with him.

23. Mr Colman referred the Tribunal to Dr Chopra’s extensive CPD certificates appended to his witness statement, courses, and the wider remediation that Dr Chopra has undertaken, largely encompassing the areas of concern arising both from the admitted failings and also those that the Tribunal has found proved.

24. Mr Colman submitted that in response to the Tribunal’s findings in the cases of Patients J, M and N, Dr Chopra immediately sought out and booked himself on a full day course on Telephone Consultations and Triage Skills Training at the RCGP in June 2019. He referred the Tribunal to Dr Chopra’s reflective writing and submitted that Dr Chopra’s remediation has been appropriately targeted and enthusiastically embraced and that Dr Chopra had demonstrated exemplary engagement and progress. He submitted that Dr Chopra’s reflection was heartfelt and insightful and that the changes in his performance have become embedded in his practice.
25. Mr Colman submitted that XXX on Dr Chopra and his determination not merely to comply with them but to go well beyond their requirements have resulted already in a successful exercise in professional regulation. He submitted that Dr Chopra’s professional performance was deficient but that it is no longer and that there was no continuing risk to patients.

26. Mr Colman submitted that the Tribunal have to decide whether Dr Chopra’s fitness to practice is currently impaired and unlike misconduct cases, it is difficult to see where the public interest would lie in finding impairment for past deficient performance which has already been remediated. He submitted that this may be an unusual situation but invited the Tribunal to consider what more could Dr Chopra be required to do that would uphold proper standards and maintain confidence in the profession beyond what he has done already. He submitted that the public would be positively reassured by a finding, that after three years of careful supervision XXX and equally careful compliance by Dr Chopra, his previous performance failures have been thoroughly addressed and remedied.

27. Mr Colman submitted that if the Tribunal’s decision allows, Dr Chopra would like to remain at the Harold Road Surgery and they would very much like him to stay. He concluded by inviting the Tribunal to find that Dr Chopra’s current fitness to practise not impaired.

The Relevant Legal Principles

28. 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.

29. In approaching the decision, the Tribunal was mindful of the two stage process to be adopted: first whether the facts as found proved amounted to deficient professional performance and then whether any finding of deficient professional performance leads to a finding of impairment.

30. The Tribunal must determine whether Dr Chopra’s fitness to practise is impaired today, taking into account Dr Chopra’s performance 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.

The Tribunal’s Determination on Impairment

Deficient Professional Performance
31. The Tribunal first considered whether the facts found proved, amounted to deficient professional performance that was seriously below the standard expected of a medical practitioner.

Patient A

32. The Tribunal noted that paragraphs 1, 2 and 3 of the Allegation, now found proved in relation to Patient A, involved treatment, assessment and record keeping. The record keeping failures included a failure to both record an appropriate history and a failure to record the treatment given. Dr Chopra accepted that his failings were seriously below the standard expected in relation to Patient A. It noted that the experts were in agreement that these deficiencies amounted to professional performance that was seriously below the standard expected. The Tribunal determined that Dr Chopra’s treatment, assessment and record keeping together amounted to a standard seriously below that which is required.

Patient B

33. The Tribunal noted the three paragraphs of the Allegation in relation to Patient B involved treatment. Dr Chopra accepted that his failings were seriously below the standard expected in relation to Patient B. The Tribunal had regard to Dr AB’s opinion that Dr Chopra’s treatment of Patient B over this three year period was seriously below the standard expected overall. Although Dr AC considered Dr Chopra’s referral of Patient B mitigated to a degree Dr Chopra’s failings, he agreed with Dr AB. The Tribunal determined that overall Dr Chopra’s treatment of Patient B was seriously below the standard expected.

Patient C

34. The Tribunal noted that the paragraphs of the Allegation in relation to Patient C involved treatment and record keeping. Dr Chopra accepted that his failings were seriously below the standard expected in relation to Patient C. Whilst Dr AB considers that Dr Chopra’s record keeping was below the standard expected, he considered Dr Chopra’s treatment choice for this patient was inappropriate and seriously below the expected standard. Dr AC agreed. Both experts noted that no actual harm came to Patient C. The Tribunal considered that in relation to Dr Chopra’s treatment of Patient C, his performance was seriously below the standard expected. In relation to Dr Chopra’s record keeping in relation to Patient C, the Tribunal accepted the experts’ opinion that it was below the standard expected.

Patient D
35. The Tribunal noted that the paragraphs of the Allegation in relation to Patient D involved record keeping. Dr Chopra accepted that his performance was below rather than seriously below the standard expected in relation to Patient D. The Tribunal noted that both experts considered that Dr Chopra’s failure to record advice was below, but not seriously below the standard expected. The Tribunal agreed with the experts’ opinion.

Patient E

36. The Tribunal noted that the paragraphs of the Allegation in relation to Patient E involved record keeping. Neither expert considered this to be a failure seriously below the standard expected. The Tribunal accepted their opinions. The Tribunal determined that it was below the expected standard, but not seriously below the standard expected.

Patient F

37. The Tribunal noted that the paragraphs of the Allegation in relation to Patient F involved assessment and record keeping. In relation to paragraph 12a of the Allegation, Dr AB’s opinion was that this was seriously below the standard expected because there was real risk to the patient in Dr Chopra not adequately measuring the size of the cellulitis. The Tribunal agreed with Dr AB and found that Dr Chopra’s performance, in this regard, was seriously below the standard expected.

38. It was Dr AB’s opinion that record keeping failures fell seriously below the standard expected. The Tribunal noted that it was Dr AC’s opinion that the record keeping fell below, but not seriously below the standard expected. It also noted that Dr AC only provided an opinion in relation to record keeping failures with regard to the appointment of 21 July 2015, but gave no opinion as to the record of the 3 August 2015 appointment. The Tribunal accepted the opinion of Dr AB and determined that taken together the record keeping failures were seriously below the standard expected because the patient was at serious risk of future harm.

Patient G

39. The Tribunal noted that the paragraphs of the Allegation in relation to Patient G involved record keeping, in circumstances where Dr Chopra was carrying out an assessment of Patient G’s chronic depression. Both experts considered that this failure was seriously below the expected standard. The Tribunal accepted their opinion and determined this to be seriously below the standard expected.

Patient H
40. The Tribunal noted that the paragraphs of the Allegation in relation to Patient H involved record keeping and treatment at one appointment on 5 August 2015. Dr Chopra accepted his record keeping was deficient in relation to Patient G’s alcohol dependant syndrome but denied the Allegation in relation to the patient’s shingles and any criticism regarding his prescribing associated with it. The experts were of limited assistance regarding Dr Chopra’s performance. The Tribunal found that there were serious failures to record important aspects of the consultation with regard to two significant disorders and that there was a serious treatment failure. It was the Tribunal’s judgment that together these failures amounted to deficient professional performance that was seriously below the expected standard.

Patient I

41. The Tribunal noted that the paragraphs of the Allegation in relation to Patient I involved treatment and record keeping. Dr Chopra accepted that his failings were seriously below the standard expected in relation to Patient I. Both experts were in agreement that the prescribing of medication when there was no clinical indication was seriously deficient practice and therefore seriously below the standard expected. The Tribunal accepted the experts’ opinion and determined this to be seriously below the standard expected.

Patient J

42. The Tribunal noted that the paragraphs of the Allegation in relation to Patient J involved assessment and record keeping. Dr Chopra accepted that the record keeping failures were below the standard expected but he denied the assessment was inadequate. Dr AB considered both Dr Chopra’s assessment and record keeping to be seriously below the standard expected. Dr AC’s opinion as to the seriousness is in part based upon his acceptance of Dr Chopra’s case that the patient’s daughter had informed Dr Chopra of her father’s treatment in Thailand, when the Tribunal had found otherwise. The Tribunal preferred Dr AB’s opinion as to Dr Chopra’s deficient performance. It determined that there was a strong imperative, given Patient J’s medical history and recent travel to Thailand, for Dr Chopra to assess Patient J face to face and to make a full record. The Tribunal determined this to be seriously below the standard expected.

Patient K

43. The Tribunal noted that the paragraphs of the Allegation in relation to Patient K involved treatment and record keeping. Dr Chopra accepted that his failings were seriously below the standard expected. Dr AA was critical of Dr Chopra’s prescribing and considered it to be seriously below the expected standard, but this was based
on Dr Chopra’s prescribing on two occasions. However, the Tribunal was mindful that only the prescribing on 15 January 2016 had been found proved and therefore considered how far below the expected standard Dr Chopra’s failures were on that single occasion. The Tribunal took into account that this prescription was significantly too high a dose and placed Patient K at high risk of harm. The Tribunal determined this to be seriously below the standard expected.

44. It was Dr AA’s opinion that the record keeping was below the standard expected. Dr AC did not disagree with Dr AA’s opinion. The Tribunal agreed with the experts that the record keeping was below, but not seriously below the standard expected.

Patient L

45. The Tribunal noted that the paragraphs of the Allegation in relation to Patient L involved assessment, treatment and record keeping. Dr Chopra accepted that his failings were seriously below the standard expected. It was Dr AB’s opinion that the series of errors in relation to this patient amounted to assessment and treatment that was seriously below the standard expected. Dr AC expressed no clear opinion. The Tribunal determined that Dr Chopra’s failure to diagnose and treat Patient L’s diabetes properly amounted to performance that was seriously below the standard expected.

Patient M

46. The Tribunal noted that the paragraphs of the Allegation in relation to Patient M involved assessment and record keeping. Dr Chopra admitted that his failing in relation to the assessment had fallen seriously below the standard expected, but considered that his failure to record the safety netting was below but not seriously below the standard expected. Dr AB’s opinion was that Dr Chopra’s failures were seriously below the standard of care expected. As the Tribunal set out in its determination on Facts, given that Dr AC’s evidence was based on an incorrect factual assumption, his opinion as to the seriousness of this failing was of limited use to the Tribunal. It preferred Dr AB’s opinion as to the seriousness of these failings. The Tribunal determined that the deficiencies in relation to the assessment and record keeping were seriously below the standard expected.

Patient N

47. The Tribunal noted that the paragraphs of the Allegation in relation to Patient N involved assessment. Dr Chopra accepted that his failings were seriously below the standard expected in relation to Patient N. Both experts were in agreement that this fell seriously below the standard expected. The Tribunal accepted the opinion of Dr AC.

MPT: Dr CHOPRA
the experts and determined that Dr Chopra’s failures to assess Patient N’s head injury fell seriously below the standard expected.

Patient O

48. The Tribunal noted that the paragraphs of the Allegation in relation to Patient O involved treatment and record keeping. Dr Chopra accepted that his failings were seriously below the standard expected in relation to Patient O. Patient O was a 93 years old man with a history of falls. Both experts were in agreement that Dr Chopra’s care in this regard fell seriously below the standard expected. Dr AA’s opinion was that Dr Chopra’s prescribing and record keeping were seriously below the standard expected, but it was clear to the Tribunal that Dr AA’s focus was on Dr Chopra’s treatment of Patient O placing him at risk of further falls. The Tribunal determined that Dr Chopra’s treatment of Patient O fell seriously below the standard expected as Patient O was placed at increased risk of falling.

49. The Tribunal agreed with Dr AC in relation to the record keeping, that it was sub-standard. However, the Tribunal determined that the record keeping itself was below, rather that seriously below the standard expected.

Patient P

50. The Tribunal noted that the paragraphs of the Allegation in relation to Patient P involved record keeping and assessment on two separate occasions on 29 April 2016 and 22 June 2016. Dr Chopra accepted that his failings were seriously below the standard expected in relation to Patient P on 26 April 2016 and continued to be seriously below the standard expected on 22 June 2016. Both experts were in agreement that this was seriously below the standard expected. It was Dr AA’s opinion that Dr Chopra’s failings on the 26 April 2016 were seriously below the standard expected because his significant failures resulted in him failing to put himself in a position to enable a diagnosis of Patient P’s prostate cancer to be made and a treatment plan formulated. The Tribunal disagreed with Dr AA’s assessment that a mirror set of failings on 22 June 2016 were merely below the standard expected. It determined the assessment of the 22 June 2016 compounded the previous failings and amounted to a further missed opportunity. For these reason the Tribunal determined that Dr Chopra’s failures on both 29 April 2016 and 22 June 2016 amounted to performance which was seriously below the standard expected.

Patient Q

51. The Tribunal noted that the paragraphs of the Allegation in relation to Patient Q involved treatment. It was Dr Chopra’s case that this prescription was reasonable. Dr AA considered that Dr Chopra’s prescribing on 2 March 2016 was below the standard expected.

MPT: Dr CHOPRA
required standard, but in view of the subsequent monitoring, was not seriously below. The Tribunal determined that this was below, but not seriously below the standard required.

Patient R

52. The Tribunal noted that the paragraphs of the Allegation in relation to Patient R involved treatment. Dr Chopra accepted that his failings were seriously below the standard expected in relation to Patient R. These paragraphs relate to Dr Chopra’s inappropriate prescribing of aciclovir three times a day on separate occasions over a period of some twelve months to a patient with shingles. Both experts were in agreement that Dr Chopra’s care in this regard fell seriously below the standard expected. The Tribunal noted that Patient R was put at risk of incomplete and inadequate treatment and increased harm. For these reasons the Tribunal determined that Dr Chopra’s treatment of Patient R fell seriously below the standard expected.

Patient S

53. The Tribunal noted that the paragraphs of the Allegation in relation to Patient S involved treatment. Dr Chopra accepted that his failings were seriously below the standard expected in relation to Patient S. Both experts were in agreement that they fell seriously below the standard expected. The Tribunal noted that Dr Chopra exceeded the maximum dose of medication and exposed Patient S to significant risk to potentially dangerous side effects and it therefore determined that this fell seriously below the expected standard.

Conclusion on deficient professional performance

54. In the Tribunal’s judgement, Dr Chopra’s failings which it has determined as being seriously below the expected standard amount to deficient professional performance. The Tribunal determined that Dr Chopra’s deficient professional performance had been demonstrated, as Mr Colman conceded, by reference to a fair sample of Dr Chopra’s work.

Impairment

55. The Tribunal then went on to consider if the facts found proved and judged to be deficient professional performance that was seriously below the standard expected led to Dr Chopra’s fitness to practise being impaired now.

56. The Tribunal had regard to the relevant paragraphs of GMP, in particular paragraphs 8 and 11, which state:
"8. You must keep your professional knowledge and skills up to date."

...

11. You must be familiar with guidelines and developments that affect your work."

The Tribunal considered that the body of evidence found proved demonstrated that Dr Chopra’s practice fell seriously below the expected standard required demonstrating that he had not kept his professional knowledge and skills up to date, nor had he remained familiar with guidelines and developments affecting his work.

57. The Tribunal also had regard to paragraphs 15a and 16a respectively, which state:

"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..."

And:

"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..."

58. The Tribunal went on to consider paragraph 21a-d of GMP, which state:

"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..."

59. The Tribunal considered that the majority of Dr Chopra’s failures were in relation to his assessment and treating practice. It also determined that the facts found proved demonstrated that multiple patients records were inadequate and fell far short of the standard as set out in GMP.
60. The Tribunal considered that Dr Chopra had placed patients at unwarranted risk of harm by his deficient professional performance. It also considered that Dr Chopra had brought the profession into disrepute and that his failures breached fundamental tenets of the profession. The Tribunal was therefore satisfied that Dr Chopra’s fitness to practice, at the relevant time, was impaired due to his deficient professional performance.

61. The Tribunal went on to consider whether Dr Chopra’s fitness to practice was currently impaired due to his deficient professional performance. It considered whether his deficiencies were capable of being remediated. It was satisfied that the deficiencies Dr Chopra demonstrated were areas of practice that could be improved through practical steps with the appropriate training, education, supervised practice and commitment by Dr Chopra.

62. The Tribunal went on to consider whether the deficiencies had been remediated. The Tribunal had regard to a remediation bundle including evidence of audit and reflection. The Tribunal had regard to the fact that Dr Chopra had been working with his clinical supervisors since 2016 as a result of concerns raised by NHS England. It noted that the reports from his clinical supervisors clearly indicate that Dr Chopra engaged enthusiastically and wholeheartedly to improve his performance.

63. The Tribunal noted that in 2017 Dr Chopra moved practices to the Harold Road Surgery where Dr X became his clinical supervisor. It noted that there were numerous, thorough and detailed reports from Dr X which demonstrated that Dr Chopra continued to improve in his assessment of his patients, his treatment decisions and his record keeping. The Tribunal also noted that the Clinical Supervisor’s reports targeted, but was not limited to, the areas of Dr Chopra’s deficiencies. It had reports before it from the Clinical Supervisor dating from 12 June 2017 and they continued regularly into 2019.

64. The Tribunal noted that with regard to note keeping, Dr X wrote in his January 2019 Supervision Report that "Dr Chopra has good note keeping and is an example to the rest of the doctors”.

65. XXX. It also noted that Dr Chopra’s Clinical Supervisor, Dr X, stated in his report dated 28 April 2018, that he was willing to offer Dr Chopra a permanent position at his surgery.

66. The Tribunal had regard to Dr Y’s reports, Dr Chopra’s Educational Supervisor, the first dated 29 June 2017 and his subsequent reports, including the most recent, dated 6 February 2019, in which he stated:

"Conclusion

MPT: Dr CHOPRA
Having been working with Dr Chopra for over eighteen months now, I have been very impressed by the manner in which he has followed all advice and tasks. He has gone beyond my requests in a humble but positive manner. His educational input has been extensive. We have covered in detail any areas uncovered in previous audits including detailed tutorials on

- Note keeping.
- Studies of The BNF, for example correct use of Esomeprazole/Pantoprazole.
- Alcohol dependence management.
- Treatment of Herpes Zoster.
- Skin lesions.
- Prostate/Lower Urinary Tract Infections.
- Hypertension/general cardiology.
- Head injuries.
- Diabetes management/ Metformin

The audit was very positive and showed a clinician thorough in his approach, correct management across a broad range of disease areas and a safeguarding approach to patient outcomes."

The Tribunal noted that the areas targeted specified the deficiencies in Dr Chopra’s practice in his assessment, treatment and record keeping but also went wider than that to include other areas of learning.

67. The Tribunal had regard to Dr Chopra’s written reflective statement. It was clear to the Tribunal that Dr Chopra acknowledged that his practise had been seriously deficient and understood the need to improve and had made serious efforts to do so. From Dr Chopra’s reflective piece, the Tribunal considered the following:

"On reflection I am grateful to the GMC for enabling me to identify my shortcomings and giving me an opportunity to address them in the best way possible. I am humbled and have embraced my new role as a salaried GP..."

68. The Tribunal considered that Dr Chopra’s insight into his failings is fully developed. Not only does he understand the impact on him, it is clear to the Tribunal that he understands the negative impact on those patients affected, patients generally and on the wider public confidence in the medical profession. It had further regard to Dr Chopra’s reflective piece in which he states:

"I express sincere regret for the harm I have caused to the patients who have suffered as a result of my poor judgement. This is the result of a series of
mistakes which have [sic] changed my life at every level to the extent that I never want to be in such a position again. I also appreciate the impact my poor practice would have on the public’s perception of the profession and the public’s confidence and I apologise for the impact my errors have had on the wider medical profession.”

And further:

“I would like to start by expressing my sincere apologies to Patient P and his family. I feel ashamed and inadequate at all levels that his Prostate Cancer was missed and I in part was to blame for this. No amount of apologies can change his situation but hopefully with the learning and insight I have developed such a situation would not arise again.”

69. The Tribunal was satisfied that Dr Chopra’s expression of remorse and regret were entirely genuine.

70. The Tribunal then considered all Dr Chopra’s CPD evidence before it and his witness statement. The Tribunal noted that Dr Chopra’s extensive CPD included a significant amount targeted at the specific matters and areas of deficiency in this case. The Tribunal noted that it was clear from the reports from both his Clinical and Educational Supervisors that Dr Chopra had applied this learning and embedded it in his normal practice.

71. The Tribunal went on to have regard to the numerous testimonials in this case. It accepted that these were written in the full knowledge of the Allegations against Dr Chopra and this was accepted by the GMC. The Tribunal was struck by the level of persistent and recurrent clear themes running through the testimonials that Dr Chopra had established and maintained a positive relationship with patients. They spoke highly of his caring and attentive nature and of the fact that they never felt rushed in his consultations.

72. The Tribunal paid particular attention to testimonial’s from Dr Chopra’s current colleagues which demonstrate that he is currently working as a very effective general practitioner.

73. For all these reasons and having taken into consideration all the evidence before it, the Tribunal determined that Dr Chopra had fully remedied all of his deficiencies.
74. In the Tribunal’s judgement Dr Chopra is highly unlikely to repeat his failings. It was satisfied that patients under his care would be cared for safely and effectively in accordance with the standards expected of a medical professional.

75. The Tribunal then went on to consider whether a finding of impairment on public interest grounds was necessary. It was satisfied that no such finding was required, since an informed member of the public would be confident that Dr Chopra’s three years of successful remediation had addressed all of the concerns raised in this case and that he was determined not to repeat his failings. Making a finding of impairment, in the Tribunal’s view, would be not in the public interest.

76. The Tribunal noted that Dr Chopra had indicated within the evidence that it was his wish that he would stay within a supportive practice. However, the Tribunal was satisfied that he had changed his approach and with that positive approach and attitude he will be fit to practice unrestricted wherever he is working.

77. For all these reasons, the Tribunal determined that Dr Chopra’s fitness to practise was not currently impaired.

**Determination on Warning** - 24/04/2019

235. Having determined that Dr Chopra’s fitness to practise is not impaired, the Tribunal considered whether, in accordance with s35D(3) of the 1983 Act, a warning should be issued.

**Submissions on behalf of the GMC**

236. In summary, Ms Duckworth referred the Tribunal to GMC’s Guidance on Warnings (February 2018) and the Sanctions Guidance (February 2019). Ms Duckworth submitted that a formal warning should be issued because there had been a serious departure from the standards as set out in GMP, and a warning was needed to maintain good medical standards, public confidence in the medical profession and to prevent any repetition. She submitted that a warning is a serious response where a finding just below the threshold for a finding of impairment and works as a deterrent in circumstances where any future finding could lead to a finding of impairment. She submitted that the breaches of GMP in this case warrant a warning.

237. Ms Duckworth submitted that in relation to mitigation the Tribunal may take into account that it had found Dr Chopra to have: gained insight, expressed genuine regret and remorse and acknowledged his failings and the need to improve. Further, she submitted that Dr Chopra’s remediation and the fact that there had been no repetition could be considered as mitigation. She submitted there had been multiple failings over a
number of years and that these matters could not be considered as isolated concerns. Ms Duckworth submitted that in light of the serious findings the Tribunal had made, a warning would mark the deficiency and remain for two years.

Submissions on behalf of Dr Chopra

238. In summary, Mr Colman referred the Tribunal to the relevant paragraphs of the Guidance on Warnings. He submitted that a warning allows the GMC and MPTS Tribunals to indicate to a doctor that any given conduct, practice or behaviour represents a departure from the standards expected of members of the profession and should not be repeated. He referred the Tribunal to its determination at Stage 2 in which he submitted its findings were a public reproach to that effect. He also invited the Tribunal to consider that as it had determined that Dr Chopra was highly unlikely to repeat his failings, that decision weighs against the requirement for a warning.

239. Mr Colman invited the Tribunal to consider that given the terms and function of a warning, it will normally be appropriate to issue a warning following a specific breach of GMP or allegation of misconduct rather than more generalised concerns about the standard of a doctor’s practice.

240. Mr Colman submitted that Dr Chopra has strong mitigation as already found by this Tribunal at Stage 2 in which it determined Dr Chopra has: fully developed insight, expressed entirely genuine remorse and regret, and a previous good history. Further, he submitted that there has been no repetition, that the deficiencies are highly unlikely to be repeated and Dr Chopra has achieved full remediation and embedded it in his practice. Mr Colman concluded that given these findings, a warning would be disproportionate.

The Tribunal’s Approach

241. The Tribunal had regard to the Guidance on Warnings in making its decision as to whether a warning would be appropriate in the circumstances of Dr Chopra’s case. It considered the principle of proportionality, weighing the public interest with Dr Chopra’s interests.

242. The Tribunal bore in mind that warnings allow MPTS Tribunals to indicate to a doctor that any given conduct, practice or behaviour represents a departure from the standards expected of members of the profession and should not be repeated. Warnings are a formal response in the interests of maintaining good professional standards and public confidence in doctors.
The Tribunal’s Determination on Warning

243. The Tribunal had regard to paragraph 16 of the Guidance on Warnings, which states:

"The test for issuing a warning

16. A warning will be appropriate if there is evidence to suggest that the practitioner’s behaviour or performance has fallen below the standard expected to a degree warranting a formal response by the GMC or by a MPTS tribunal. A warning will therefore be appropriate in the following circumstances:

- there has been a significant departure from Good medical practice, or ...”

244. The Tribunal was mindful of paragraph 20 in the guidance on warnings, which states:

"20. The decision makers should take account of the following factors to determine whether it is appropriate to issue a warning.

a. There has been a clear and specific breach of Good medical practice or our supplementary guidance.

...

c. A warning will be appropriate when the concerns are sufficiently serious that, if there were a repetition, they would likely result in a finding of impaired fitness to practise. Warnings may be an appropriate response to any type of allegation (subject to the comments in paragraph 7 regarding cases solely relating to a doctor's health); the decision makers will need to consider the degree to which the conduct, behaviour or performance could affect patient care, public confidence in the profession or the reputation of the profession. If the decision makers consider that a warning is appropriate, the warning should make clear the potential impact of the conduct, behaviour or performance in question, accordingly.

d. There is a need to record formally the particular concerns (because additional action may be required in the event of any repetition).”

245. The Tribunal took into account that there had indeed been a significant departure from GMP in the care Dr Chopra provided to patients in relation to
assessment, treatment and record keeping over a period of five years. It found a number of these departures to have amounted to serious failures.

246. The Tribunal bore in mind that Dr Chopra's practice was a busy single-handed one and that failings occurred over the course of almost 5 years. The Tribunal recognised that the deficient professional performance finding was based on a fair sample of Dr Chopra's work.

247. The Tribunal were satisfied that these deficiencies are of a nature that, were there to be any repetition, it is likely that a finding of impairment would be made.

248. The Tribunal determined that there is a need to formally record the particular concerns raised in this case. It noted that its determination in relation to these concerns are a matter of public record and that the GMC will retain it for future reference should any regulatory concerns arise in relation to Dr Chopra's future practice.

249. The Tribunal went on to consider proportionality in weighing the interests of the public with those of Dr Chopra. It noted that Dr Chopra had fully embraced XXX, engaged with his clinical supervisors diligently and wholeheartedly to improve his performance. His significant evidence of CPD and remediation led this Tribunal to the conclusion that his fitness to practice was not impaired. The Tribunal were satisfied all these factors are relevant here and that the risk to public confidence and the reputation on the medical profession had been allayed.

250. The Tribunal also had regard to paragraph 33 of the Guidance on Warnings, which states:

"33 However, if the decision makers are satisfied that the doctor’s fitness to practise is not impaired or that the realistic prospect test is not met, they can take account of a range of aggravating or mitigating factors to determine whether a warning is appropriate. These might include:

- the level of insight into the failings.
  a A genuine expression of regret/apology.
  b Previous good history.
  c Whether the incident was isolated or whether there has been any repetition.
  d Any indicators as to the likelihood of the concerns being repeated.
  e Any rehabilitative/corrective steps taken.
  f Relevant and appropriate references and testimonials."

**Record of Determinations – Medical Practitioners Tribunal**
251. The Tribunal was satisfied that Dr Chopra’s expression of remorse and regret were entirely genuine. It noted that prior to the matters before it there had been no previous concerns and there had been none since. It noted that Dr Chopra had worked under varying degrees of supervision for 2-3 years and complied with XXX. Whilst the Tribunal fully acknowledged that Dr Chopra’s failings did not amount to an isolated incident, it bore in mind the extensive and thorough remediation Dr Chopra had achieved as it set out in its determination at Stage 2.

252. The Tribunal noted that there was currently no indication that the deficient professional performance was likely to be repeated. The Tribunal was satisfied that Dr Chopra had changed fundamentally his approach and with that positive approach and attitude he will be fit to practice unrestricted wherever he is working. Given the evidence the Tribunal had received as to Dr Chopra’s diligent and wholehearted efforts to improve and embrace the need to remediate, it determined that even if Dr Chopra were to return to single-handed practice it was highly unlikely that the concerns before this Tribunal would be repeated.

253. The Tribunal was satisfied that Dr Chopra could not have done more in his efforts to remediate the concerns raised and has been successful in remediating his deficiencies fully as have already been set out by this Tribunal. It considered that the appropriate references and testimonials in support of Dr Chopra also provided considerable mitigation in relation to his failings.

254. The Tribunal had full regard to the seriousness of the findings of deficient professional performance but it was impressed by the extent to which Dr Chopra had remediated his failings. It noted that Dr Chopra was closely scrutinised by his supervisors given XXX he was subject to. The Tribunal was satisfied that Dr Chopra had fully remediated and committed himself to ensuring his future practice is of the appropriate standard within GMP.

255. The Tribunal weighed all the evidence before it and determined that no warning was required.

256. XXX

257. That concludes this case.

Confirmed
Date 24 April 2019

Dr Matthew Fiander, Chair
ANNEX A – 05/04/2019

Application to amend the Allegation

1. Ms Duckworth made an application to amend paragraph 14 of the Allegation pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ("the Rules"). She submitted that the application was to add an alternative Allegation in relation to a recording error and associated necessary grammatical changes to sub-paragraphs 14a (i) and (ii).

2. Ms Duckworth proposed the following amendment to paragraph 14 of the Allegation:

14. On 5 August 2015, you:

   a. consulted with Patient G who you recorded as having a diagnosis of chronic depression. The records of this consultation were inadequate in that you failed to record details of any:

      i. details of any assessment of Patient G’s ongoing symptoms;

      ii. details of any examination you conducted;

      iii. the presenting condition accurately.

   b. prescribed co-cyprindiol 2000mg. This prescription was inappropriate in that:

      i. an alternative contraception should have been offered;

      ii. co-cyprindiol is not licensed as a primary contraceptive;

      iii. it was contrary to the guidance contained in the British National Formulary.

3. Ms Duckworth submitted that the Tribunal has to determine whether there were recording errors relating to the assessment and examination of the patient’s chronic depression. She submitted that the Tribunal should allow an additional subparagraph in the alternative to represent evidence which it had heard in the hearing relating to an error about the inputting of the presenting condition.
4. Ms Duckworth submitted that Rule 17(6) requires a Tribunal to consider whether an amendment can be made without injustice. She submitted that throughout these proceedings Dr Chopra has admitted several recording issues as reflected in the charges. She submitted that although further recording errors have been identified in the evidence, these have not been charged.

5. Ms Duckworth submitted that when considering the issue of injustice, this application is appropriate and proportionate. She acknowledged that whilst this Allegation could have been charged at the beginning of proceedings, this is a matter for the Tribunal to decide. Ms Duckworth submitted in support of her application, that there are 39 allegations and over 100 facts for the Tribunal to consider, many admitted and found proved and had all the recording issues been charged the number of allegations would have been much increased.

**Submissions on behalf of Dr Chopra**

6. Mr Colman submitted that the proposed amendment adds a further allegation. He submitted that the proposed amendment is to Dr Chopra’s prejudice.

7. Mr Colman submitted that this application has been made at the last minute at the close of the Facts stage. He submitted that the procedural safeguards require the GMC to draft and notify a doctor of allegations he faces in advance under Rule 15. He submitted that the amendment cannot be made without injustice to Dr Chopra as it will result in him facing a further allegation of which he was not notified in advance. Therefore this application is opposed.

**The Tribunal’s decision**

8. The Tribunal bore in mind the provisions set out in Rule 17(6) of the Rules. It considered that making the proposed amendment after all the evidence on facts had been heard would be unjust to Dr Chopra. The GMC has been aware of the evidence in this case and Dr Chopra’s statement in response to paragraph 14 of the Allegation well in advance of the hearing in which he clearly states that the entry in the notes which relates to chronic depression was a coding error.

9. The Tribunal considered that the proposed amendment it not a mere technical or procedural amendment, but a material change adding a further allegation to the case denying Dr Chopra an earlier opportunity to address the Allegation which the Tribunal consider unfair. The Tribunal considered that no sufficient reason had been provided as to why Dr Chopra was not notified of this additional allegation at a much earlier stage.
10. The Tribunal determined that given this application has come after the conclusion of both the GMC and defence cases, it would be unjust to allow the proposed amendment. The Tribunal has determined to reject the application.
Application to amend the Allegation

1. On day 3 of the hearing Ms Duckworth made an application to amend paragraph 21 of the Allegation and withdraw paragraphs 23 and 24 pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended (‘the Rules’).

2. Ms Duckworth submitted that following additional information received from Patient K through a further communication, Patient K confirmed that he had received treatment for hypertension prior to his having seen Dr Chopra. Ms Duckworth submitted that this had led to the experts reviewing their opinions.

3. Ms Duckworth submitted that the evidence no longer supported these paragraphs of the Allegation as drafted. She submitted that the proposed amendment in relation to paragraph 21 now represented concerns in relation to Dr Chopra’s record keeping as opposed to his prescribing.

4. Ms Duckworth also submitted that she was seeking to confine the proposed amended paragraph 21 to the date of the consultation, in fairness to Dr Chopra.

5. Ms Duckworth invited the Tribunal to allow the GMC to withdraw paragraphs 23 and 24 altogether given the experts’ revised Joint Expert Report as there is now no evidence to support these paragraphs and they therefore could not be found proved.

6. Ms Duckworth proposed the following amendments:

   21. On 11 November 2015, you consulted with Patient K during which you prescribed losartan 50mg. This prescription was inappropriate. The records of this consultation were inadequate in that you:

       a: it was based on only one blood pressure reading recorded this as a first consultation for hypertension, when the patient had been attending at the practice for management of his blood pressure since September 2013;

       b: ambulatory home readings should have been arranged first failed to record:
i. that the patient was doing home readings to monitor his blood pressure;

ii. what the home readings were.

22. On 15 January 2016, you consulted with Patient K and changed the prescription to candesartan 32 mg. This prescription was inappropriate in that:

a. the losartan should have been increased to 100mg instead;

b. the dose of candesartan was too high.

23. On 2 February 2016, you consulted with Patient K and you reduced the dose of candesartan to 16mg, which was an insufficient reduction.

24. On 4 March 2016, you consulted with Patient K. Patient K’s blood pressure reading was 121/66. You:

a. failed to reconsider the original diagnosis of essential hypertension;

b. failed to consider stopping all treatment;

c. placed Patient K at risk of having too low a blood pressure

7. Mr Colman made no objections to Ms Duckworth’s application. He submitted on behalf of Dr Chopra that the amended Allegations as proposed by Ms Duckworth in relation to 21a and b would be admitted and found proved.

8. The Tribunal was satisfied that there would be no injustice in granting the proposed amendment as set out and therefore acceded to the application.
Record of Determinations –
Medical Practitioners Tribunal

Schedule 1
22 September 2014
29 September 2014
22 October 2014 31 October 2014
6 November 2014
3 December 2014

Schedule 2
6 July 2015 – 400 mg of aciclovir five times a day for five days
2 February 2016 – 800 mg of aciclovir three times a day for five days – 35 tablets issued
28 June 2016 – aciclovir 800 mg tablets. One to be taken three times a day 25 tablets