General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

Remote video link hearing

20-23 January 2025

Registrant name:	Ravinder Walia (nee Tulsi)
Registration number:	2046597
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Manuela Grayson (Chair) Jignesh Patel (Registrant member) Stephanie Hayle (Lay member)
Committee Secretary:	Sameen Ahmed
Registrant:	Not present and not represented at the hearing
General Pharmaceutical Council:	Represented by Louise Hartley, Case Presenter
Facts proved:	1 in its entirety; 2.1, 2.2, 2.3, 3, 4.
Facts not proved:	2.4
Fitness to practise:	Impaired
Outcome:	Suspension of four months
Interim measures:	Interim suspension

This decision including any finding of facts, impairment and sanction is an appealable decision under *The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010*. Therefore, this decision will not take effect until Thursday 20 February 2025 or, if an appeal is lodged once that appeal has been concluded. However, the interim suspension set out in the decision takes effect immediately and will lapse when the decision takes effect or once any appeal is concluded.

Particulars of Allegation (as amended)

"You, a registered pharmacist, whilst working as a pharmacist at the Village Pharmacy, 7 Eton Wick Road, Eton Wick, Windsor, Berkshire, SL4 6LT ("the pharmacy"), on 24 May 2021:

1. *Made one or more of the following comments, or words to the same effect, to Patient A in relation to autism and/or vaccinations:*

    1.1 *"Oh it's fine, he'll grow out of it, my daughter did";*

    1.2 *"My daughter had it when she was younger, and as she's grown older she has grown out of it and doesn't have it anymore";*

    1.3 *"It isn't lifelong, you can take vitamins; and vaccinations are the reason that a lot of children have autism".*

2. *Said to Patient A words to the effect of:*

    2.1 *doctors have proven that the MMR vaccine is the reason that people have autism; and/or*

    2.2 *one in every hundred children who had the MMR vaccination developed autism and/or*

2.3 *Patient A needed to detox her son from the vaccination and give him vitamins; and/or*

2.4 *Patient A should avoid any future vaccinations for her son.*

3. *Wrote "MMR" and the names of individuals and/or organisations associated with anti-vaccination views on a piece of prescription paper and then provided it to Patient A.*

4. *Your actions and/or comments at allegations 1, 2 and/or 3 above were made contrary to NHS and/or the Department of Health and Social Care's guidance on:*

    4.1 *vaccines; and/or*

    4.2 *autism.*

By reasons of the matters set out above, your fitness to practise is impaired by reason of your misconduct".

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Documentation

Document 1- Council's hearing bundle

Document 2- Council's skeleton argument

Document 3- Registrant's bundle

Document 4- Skeleton argument on behalf of the Registrant

Witnesses

a. Patient A

b. Flynn Campbell, Pharmacy Dispenser at the Pharmacy

c. Nilesh Tailor, Owner and Superintendent Pharmacist of the Pharmacy

d. Claire Sprent, Case Officer at the Council (READ)

Determination

Introduction

1. This is the written determination of the Fitness to Practise Committee at the General Pharmaceutical Council ('the Council').

2. This hearing is governed by *The Pharmacy Order 2010* ('the Order') and *The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010* ('the Rules').

3. The statutory overarching objectives for these regulatory proceedings are:

   a. To protect, promote and maintain the health, safety and well-being of the public;

   b. To promote and maintain public confidence in the professions regulated by the Council; and

   c. To promote and maintain proper professional standards and conduct for members of those professions.

4. The Committee also has regard to the guidance contained in the Council's *Good decision making: Fitness to practise hearings and outcomes guidance* as revised March 2024.

5. A Principal Hearing has up to three stages:

   Stage 1. Findings of Fact – the Committee determines any disputed facts.

   Stage 2. Findings of ground(s) of impairment and impairment – the Committee determines whether, on the facts as proved, a statutory ground for impairment is established and, if so, whether the Registrant's fitness to practise is currently impaired.

Stage 3. Sanction – the Committee considers what, if any, sanction should be applied if the Registrant's fitness to practise is found to be impaired.

Service of Notice of Hearing

6. The Committee has seen a letter dated 17 December 2024 from the Council headed 'Notice of Hearing' addressed to the Registrant and sent to her registered email address as noted on the Register.

7. The Committee was satisfied that there had been good service of the Notice of Hearing ('Notice') in accordance with Rules 3 and 16 of the Rules.

Application to proceed in the absence of the Registrant

8. The Registrant was not in attendance at this hearing, nor was someone attending on her behalf. The Committee heard submissions from Ms Hartley on behalf of the Council to proceed in the absence of the Registrant under Rule 25.

9. The Committee noted that the Registrant had completed and returned the Notice on 10 January 2025, indicating that she would not attend but that she wished the Committee to take into account her representations. It also took into account that her representative had provided a bundle of documentation on her behalf which included a witness statement from her along with a skeleton argument on her behalf. The Committee took into account noted that in the skeleton argument the Registrant had indicated to the Council that she would not be attending the hearing.

10. The Committee decided to proceed in the absence of the Registrant for the following reasons:

- The Committee had found good service of the Notice, and indeed the Registrant is aware of today's proceedings.
- The Registrant was aware that the hearing would take place and had indicated that she would not be in attendance at this hearing. She did not ask for an adjournment.
- There is a public interest in the expeditious disposal of cases.
- Not proceeding today would inconvenience witnesses who are ready to give evidence.

Application to amend the Particulars of Allegation

11. The Committee heard an application from Ms Hartley on behalf of the Council under Rule 41 to amend the particulars as follows:

1. *Made one or more of the following comments, or words to the same effect, to Patient A in relation to autism and/or vaccinations:*

(Originally: *Made one or more of the following comments, or words to the same effect to Patient A in relation to autism and vaccinations:*)

2. *Said to Patient A words to the effect of:*

(Originally: *Said to Patient A words to the effect that:*)

2.2 *one in every hundred children who had the MMR vaccination developed autism and/or*

(Originally: *the number of people who had the MMR vaccination and then developed autism and taking vitamins and/or*)

2.4 *Patient A should avoid any future vaccinations for her son.*

(Originally: *Someone cannot be detoxed from a vaccination and Patient A should avoid any future vaccinations.*)

3. Wrote "MMR" and the names of individuals and/or organisations associated with anti-vaccination views on a piece of prescription paper and then provided it to Patient A.

(Originally: *Wrote "MMR" and the names of individuals/organisations associated with antivaccination views on the back of Patient A's prescription before handing it to her.*)

12. Ms Hartley submitted that these were relatively minor amendments which would more accurately reflect what was set out in Patient A's witness statement, and would not change the way in which it would be defended: the Committee had the benefit of the Registrant's defence documentation and the Registrant had received good notice of the proposed amendments and had indicated by way of the skeleton argument produced by her then representatives, that she did not oppose the amendments. Ms Hartley submitted that the proposed amendments would not in any way prejudice the fairness of the proceedings.

13. The Committee accepted Ms Hartley's submissions on behalf of the Council and took into account that the Registrant did not oppose the proposed amendments. It was of the view that they would not prejudice the fairness of the proceedings and reflected the evidence contained within Patient A's witness statement, which the Registrant had had notice of.

14. The Committee therefore accepted the Council's proposed amendments to the Particulars of Allegation.

Application for parts of the hearing to be held in Private

15. The Committee heard an application from Ms Hartley under Rule 39(3) to hold parts of the hearing in private.

16. The Committee accepted the submissions of Ms Hartley and resolved to hear any parts of the hearing which referred to the private life or health of any person involved or their family members in private.

Registrant's response to Particulars of Allegation

17. The Registrant in her witness statement had denied particulars 1, 2 and 4 in their entirety. She admitted particular 3 on the basis that Patient A had asked her to provide the information. In these circumstances the Committee did not consider that the Registrant had made a formal admission to particular 3.

18. The Committee therefore went on to receive evidence and submissions regarding all of the Particulars of Allegation.

Background, according to the Council

19. This was a case in which the Registrant denied the Particulars of Allegation except for her acceptance of particular 3 in relation to writing and giving a document to Patient A. What is set out below, therefore, is the background, as alleged by the Council, which led to the referral, along with summaries of the evidence of the Council's witnesses.

20. On 24 May 2021 Patient A had a GP appointment, following which she attended the Pharmacy to collect her medication. She attended the Pharmacy at about 5pm with her son, who is autistic. Patient A's evidence was that she was about to leave the Pharmacy when the Registrant attempted to engage her son in a conversation.

21. Patient A alleged that there followed a conversation in which the comments as alleged in the particulars were made by the Registrant.

22. Patient A produced as evidence a piece of prescription paper, on which she says the Registrant wrote down and gave to her, the names of several antivaccination activists/organisations. Patient A's evidence was that she did not ask for this information

and did not want it; she felt uncomfortable about confronting the Registrant and did not want to be made to feel guilty for vaccinating her son.

23. Patient A then spoke to her grandmother about the exchange the following day. Patient A's grandmother suggested they went to the Pharmacy to speak to Mr Tailor, the owner

and superintendent of the Pharmacy about it. Patient A also informed her GP, who in turn also reported the concern to Mr Tailor.

24. Mr Campbell who was working in the Pharmacy during the exchange between Patient A and the Registrant, did not hear the substance of the conversation but confirmed that it took place and gave an idea of its duration, which he said was about five minutes though he could not be sure if it was a bit more or a bit less than that.

25. Claire Sprent, the Council's case investigator, conducted some online research into the names of the individuals and organisations listed on the prescription paper provided to Patient A by the Registrant. Each of these individuals and organisations has or has links with antivaccination views or activism and espouses views about the connection between MMR vaccines and autism. Her witness statement was agreed between the parties.

Decision on Facts

26. In reaching its decisions on facts, the Committee considered the documentation listed at the start of this determination, oral evidence and the submissions made by the Council.

27. When considering each particular of allegation, the Committee bore in mind that the burden of proof rests on the Council and that particulars are found proved based on the balance of probabilities. This means that particulars will be proved if the

Committee is satisfied that what is alleged is more likely than not to have happened. The Committee also took into account, when assessing the credibility of the evidence before it, that the Registrant was previously of good character.

28. The Committee observed that both the Registrant and Patient A agreed that after they had spoken about her prescription which she was hoping to collect, a further conversation was had, and that the Registrant wrote some notes on a piece of prescription paper which she handed to Patient A as alleged at particular 3. However,

their versions of how and why the conversation began, its content, and its purpose, varied significantly.

29. Patient A alleged that the conversation began when the Registrant drew her back into the Pharmacy as she and her son were leaving, She alleged that in response, the Registrant brought up the MMR vaccine and whether it can cause autism. Patient A stated in her witness statement: "I don't remember [the Registrant] saying that there was a lot of misinformation online". In her oral testimony, Patient A did not recall any discussion of the Covid vaccine nor Covid misinformation, as was alleged by the Registrant.

30. The Registrant's version, set out in her witness statement dated 11 January 2025, was as follows:

"[Patient A] instigated a discussion with me on the issue of Covid vaccinations…Patient A …said that there appeared to be a lot of information being circulated/published on the issue of Covid vaccines. In reply I commented to Patient A that I had seen various postings online and on social media about people who had in the past provided misinformation about vaccines in general and suggested she be mindful of this. I mentioned Dr Wakefield and Robert Kennedy and some of his associates that had been referenced by him on social media. I also told Patient A that the Royal Pharmaceutical Society had recently sent out

an email pharmacy alert indicating that the Covid vaccine may have the potential to cause pericarditis and myocarditis…I also outlined research figures which suggested that the MMR vaccine had potential impact on the effectiveness of the Covid vaccine. Patient A then proceeded to ask me to document some of the people I had mentioned as she intended to undertake her own research on the matter. I wrote details of the people I had mentioned on the back of a prescription and handed this to Patient A. I made this information available to Patient A at her specific request".

31. The Registrant stated that she only discovered Patient A's as they were leaving when Patient A told her. She stated: "At no point during my discussions with Patient A on 24th May 2021 was autism ever discussed".

32. The Committee considered that the evidence provided by Patient A was cogent, and consistent. She was honest when she did not recall matters, however she was clear about the tenor of the conversation and told the Committee about her own quite physical reaction to what was being said to her - her hands felt sweaty and she felt angry and upset. There was no reason advanced on behalf of the Registrant as to why Patient A might have made up her version of the conversation, and the Committee could not think of one.

33. In coming to this conclusion, the Committee took into account Patient A's evidence which was that the Registrant only began to talk about autism, its causes, potential ways to treat it, and the connection with the MMR vaccine, after she was told that Patient A's that whilst she knew that what the Registrant was saying was not true, she stayed on to see "how far she would go"; that she told both her mother and grandmother about what happened afterwards; and that the grandmother took her into the Pharmacy the next day to raise the matter with Mr Tailor.

34. The Committee also took into account that the Registrant stated that she has never discussed her family circumstances with any patient, however Patient A stated that the

Registrant told her about her own daughter. The Committee took into account that Patient A told the Committee that she had no prior knowledge of the Registrant. It considered it unlikely that Patient A would have known that the Registrant had a daughter unless a conversation along the lines described by Patient A had taken place.

35. Furthermore, the Committee did not consider it likely that the Registrant would have written the note as alleged (and admitted) at particular 3, with contents including not only the names of people and organisations who claimed there was a connection between the MMR vaccine and autism, but also more specifically, the alleged number of people in the USA who had autism "B4" 1988, if the conversation amounted, as asserted by the Registrant, to a warning against misinformation about vaccines in general or Covid vaccines in particular. It appeared to the Committee inherently more likely than not that the Registrant had provided the information to Patient A because she was trying to assist Patient A to address.

36. Having carefully considered all of the evidence before it, the Committee decided that it preferred Patient A's version of events, because, on the basis of the evidence, it was inherently more plausible.

37. Having concluded that it preferred the version of Patient A, the Committee went on to consider each particular in turn.

Particular 1

"You, a registered pharmacist, whilst working as a pharmacist at the Village Pharmacy, 7 Eton Wick Road, Eton Wick, Windsor, Berkshire, SL4 6LT ("the pharmacy"), on 24 May 2021:

1.Made one or more of the following comments, or words to the same effect, to Patient A in relation to autism and/or vaccinations:

1.1 "Oh it's fine, he'll grow out of it, my daughter did";

1.2 "My daughter had it when she was younger, and as she's grown older she has grown out of it and doesn't have it anymore";

1.3 "It isn't lifelong, you can take vitamins; and vaccinations are the reason that a lot of children have autism".

38. The Committee took into account the evidence contained within Patient A's witness statement, dated 18 May 2022. Patient A confirmed the contents of this statement in her oral evidence. She stated that as she was about to leave the Pharmacy, the Registrant tried to talk to her son and Patient A explained

39. Patient A stated that and that the Registrant made the comments attributed to her at particular 1.

40. The Committee carefully considered the documentation provided by the Registrant which included the response from her representative dated 23 June 2023 and her witness statement of 11 January 2025, and also the evidence from the Council's witnesses. It noted that in the response of 23 June 2023, the Registrant stated that "there was no ongoing discussion whatsoever about autism as detailed within Patient A's witness statement". She stated that the discussions were "solely around the dispensing of her prescription and covid vaccine information/misinformation".

41. The evidence before the Committee suggested that this was not the case. Rather, there must have been discussion about autism – and the MMR vaccine – because the note which the Registrant wrote and gave to Patient A, was very specific about those subjects.

42. The Committee found all of particular 1 proved in its entirety.

Particular 2:

2.Said to Patient A words to the effect of:

2.1Doctors have proven that the MMR vaccine is the reason that people have autism; and/or

2.2 one in every hundred children who had the MMR vaccination developed autism and/or

2.3 Patient A needed to detox her son from the vaccination and give him vitamins; and/or

2.4Patient A should avoid any future vaccinations for her son.

43. The Committee noted that Patient A stated in her witness statement that the Registrant "drew her back towards the counter". Patient A continued:

"She was speaking about the MMR vaccine and said doctors have proven that it is the reason that people have autism. She was saying the names of doctors and stated that one in every hundred children who had the MMR Vaccination developed autism, compared to people who haven't had the vaccine."

44. Patient A stated that the Registrant "didn't mention the Covid vaccination during this conversation. She said that I needed to detox my son from the vaccination and give him vitamins…I asked her 'How do I detox him?'…[the Registrant] told me to avoid any future vaccinations".

45. The Committee observed that the words set out at particulars 2.1, 2.2 and 2.3 were taken from the witness statement of Patient A. It considered that given its assessment of the context as a whole, which was that Patient A's version of events was inherently more credible, it could rely on the witness statement as a record, of what, more likely than not, was said by the Registrant.

46. The Committee therefore found sub-particulars 2.1, 2.2 and 2.3 proved.

47. As for 2.4, the Committee took into account that although there was some consistency in the wording of 2.4 with what was recorded in the Registrant's witness statement, in that Patient A had stated that the Registrant advised her to avoid any future vaccinations, the witness statement did not state specifically that the Registrant said these words in relation to Patient

A's son. The Committee was of the view that it could not be inferred or assumed that the Registrant, when, or if, she said those words, would have been referring specifically to Patient A's son.

48. The Committee therefore found sub-particular 2.4 not proved.

Particular 3:

3. Wrote "MMR" and the names of individuals and/or organisations associated with anti-vaccination views on a piece of prescription paper and then provided it to Patient A.

49. The document produced by the Council contained the following hand-written notes:

"Duckduckgo (google)

Polly Tommey

Dr Wakefield

(IG)

Dr Tenpenny

Robert F Kennedy

1988

MMR.

1 in 10 000 B4.

1988"

50. The Committee took into account that the Registrant accepted that she had written the words as alleged on the back of a prescription paper. It was aware that the individuals and/or organisations listed by the Registrant were associated with views that

attribute autism to the use of vaccinations. It also took into account the research and documentation provided by Claire Sprent of the Council, which confirmed this association.

51. The Committee went on to observe at this stage that the two parties were in conflict as to why the Registrant wrote the note and for what purpose she did so. The Registrant stated that she had mentioned the people in the note when telling Patient A about "people who had in the past provided misinformation about vaccines in general", and that Patient A had specifically requested that she write them down for her.

52. Patient A's evidence in her witness statement, was that she "didn't ask her to write down any information or ask for the names of doctors that had carried out research". When asked by the Committee about this, she confirmed that she "100% did not" ask for the information to be written down.

53. Patient A told the Committee that the Registrant seemed to be trying to be kind and was concerned. The Registrant was offering the information in order to help her with the issues she had**.**

54. The Committee considered the contents of the note written by the Registrant. It contained not only the names of people who had claimed that the MMR vaccine caused autism, but also the "1 in 10000 B4 1988" comment which Patient A said the Registrant had told her was the number in the population in the USA thought to have autism before 1988. This was the year, the Committee was told, when the MMR vaccine came into use.

55. The Committee was also of the view that it was inherently unlikely that the Registrant would have written the contents of the note, all of which referred to information about the MMR vaccine and autism (now discredited), unless she thought it would be useful to Patient A. She must therefore have known Patient A's before she wrote the note.

56. Having carefully considered both versions of events, to ascertain how the note came to be written, and the Registrant's purpose in doing so, the Committee preferred the version of Patient A.

57. The Committee found particular 3 proved on the basis of the documentary evidence, and the evidence of both Patient A and the Registrant.

Particular 4:

4.Your actions and/or comments at allegations 1, 2 and/or 3 above were made contrary to NHS and/or the Department of Health and Social Care's guidance on:

4.1 vaccines; and/or

4.2 autism.

58. The Committee had been provided with, and took into account, the official guidance on vaccines including the MMR vaccine from the UK Health Security Agency/ Department of Health & Social Care, which stated that "there is now overwhelming evidence that MMR does not cause autism..[and] there is no correlation between the rate of autism and MMR coverage in either the UK or the USA". It also took into account the information published on the NHS website, contained within the Council's bundle, which warned the public not to trust vaccine information on social media and stated: "vaccines do not cause autism- studies have found no evidence of a link between the MMR vaccine and autism". This document also set out that autism is not a medical condition and that there is no cure.

59. The Committee accepted the submissions on behalf of the Council to the effect that these matters are well established by science and contemporary research, and that the Committee could take judicial notice of them.

60. The Committee had previously concluded above that the alleged comments were in fact made, and the notes on the prescription sheet were written and provided to Patient A by the Registrant. It had also accepted Patient A's version of events in that the Registrant's motivation for providing the information was to draw Patient A's attention to concerns about the MMR vaccine, rather than to inform her about previous misinformation in connection with vaccines, as part of a conversation about Covid vaccines.

61. It followed that the Committee found particular 4 proved.

STAGE TWO: IMPAIRMENT

62. Having made its determination in relation to the facts, the Committee went on to consider whether those facts amount to misconduct and, if so, whether the Registrant's fitness to practise is currently impaired by reason of her misconduct.

63. Article 54(1) of the Pharmacy Order 2010 provides:

"The Fitness to Practise Committee must determine whether or not the fitness to practise of the person in respect of whom the allegation is made (referred to in this article as "the person concerned") is impaired".

64. The Council's recently revised Good decision making: Fitness to practise Hearings and Outcomes Guidance (March 2024), Paragraph 2.12 states:

> *"2.12 A pharmacy professional is 'fit to practise' when they have the skills, knowledge, character, behaviour and health needed to work as a pharmacist or pharmacy technician safely and effectively. In practical terms, this means maintaining appropriate standards of competence, demonstrating good character, and also keeping to the principles of good practice set out in our various standards, guidance and advice."*

65. "Misconduct" has been termed a "gateway" which may lead to a finding of current impairment. Article 51(1) of the Pharmacy Order 2010 provides that:

> *"A person's fitness to practise is to be regarded as "impaired" for the purposes of this Order only by reason of:*
> *(a) misconduct*
> *[various other grounds…]".*

Evidence

66. The Registrant had provided evidence in relation to current impairment. This included a reflective essay (undated), RPS information regarding the covid vaccination, numerous positive testimonials, evidence of membership of the RPS, a certificate for Online Vaccination Training, and evidence that she had carried out a practice test in relation to Communication Skills for a Pharmacist.

Submissions

67. Ms Hartley, on behalf of the Council, referred the Committee to her skeleton argument and the relevant law.

68. She submitted that the conduct which the Committee had found proved was in breach of Standards 1, 4, 5, and 9 of the Standards for pharmacy professionals (2017). She submitted that the Registrant's proved conduct fell far below the standards of practice to be expected of registered pharmacists and would be considered morally reprehensible and deplorable by fellow professionals; it therefore met the threshold for a finding of misconduct.

69. Turning to current impairment, Ms Hartley submitted that Rules 5(2) (a), (b) and (c) were engaged. She submitted that the Registrant's failings were attitudinal and this can be difficult to remediate: and that the reflective essay which the Registrant had provided was not sufficient to reassure the Committee that she would not repeat her conduct.

70. In relation to the wider public interest, Ms Hartley submitted that members of the public would be concerned if a finding of current impairment were not made in this case.

The Committee's Decision on Misconduct

71. The Committee took into account all of the evidence before it, including all of the evidence and documentation provided by the Registrant, the submissions on behalf of the Council, and the relevant law and guidance, including reference to the Council's "Good decision making: fitness to practise hearings and outcomes guidance" (March 2024). It bore in mind that it was a matter for its own professional judgement whether the conduct it had found proved was so serious as to amount to misconduct.

72. It took into account the Council's overarching objective which is the protection of the public, by:

- protecting, promoting and maintaining the health, safety and wellbeing of the public
- promoting and maintaining public confidence in the profession
- promoting and maintaining proper professional standards and conduct for members of the profession.

73. The Committee accepted the submissions of Ms Hartley in relation to the Council's "Standards for pharmacy professionals" (May 2017). It determined that there had been breaches of the following Standards:

a. **Standard 1: "pharmacy professionals must provide person-centred care":** Pharmacy professionals are expected to recognise their own values and beliefs but not impose them on other people. The Registrant breached the requirement to recognise and value diversity; she imposed her own values and beliefs on Patient A and she breached the requirement to take responsibility for ensuring that person-centred care was not compromised because of her own values and beliefs. The Committee was particularly concerned that in this case the official guidance on the risks to public health of misinformation about the MMR vaccine and autism was clear, yet the Registrant's comments and the contents of her note, were in conflict with such guidance.

b. **Standard 4: "pharmacy professionals must…recognise and work within the limits of their knowledge and skills, and refer to others when needed":** The Registrant gave unsolicited, incorrect and unfounded advice about the nature of autism and claims about its link with the MMR vaccine to Patient A. This was clearly outside her knowledge and skills given that it was not within the limits of her practice as a pharmacist to give advice of this sort, let alone information or advice which conflicted with DHSC guidance, making this all the more serious.

c. **Standard 5: "pharmacy professionals must use their professional judgement":**
Pharmacy professionals are expected to make care of the person their first concern and act in their best interests and recognise the limits of their competence. In sharing incorrect, unsafe information, the Registrant was acting outside the limits of her competence and not in the best interests of the patient.

d. **Standard 9: "Pharmacy professionals must not abuse their position":** The Registrant would have been aware that due to her trusted status as a pharmacist, she was more likely to have been believed by, and have an ability to influence, Patient A. Sharing potentially harmful, unsafe views about the MMR vaccine was an abuse of her position.

74. The Committee bore in mind that standards can be taken into account when considering the issues of grounds and impairment but that a breach of the Standards does not automatically result in a finding of misconduct (Rule 24(11) of the Rules).

75. The Committee carefully considered its findings on the facts. It took into account the official documentation provided by the Council from the DHSC and the NHS.

76. The DHSC Guidance on Immunisation against infectious disease, provided within the Council's bundle, explains the history and epidemiology of measles. It explains that in the late 1990s and early 2000s national vaccine coverage for children at two years of age dropped to below 80% for the MMR (one dose) due to widespread concern around the discredited link between the vaccine and autism. This led to an increase in the number of children susceptible to measles. There was an increasing number of reported cases of measles in 2012-2013, thought to be attributed to the proportion of unvaccinated 10-16 year olds who had missed vaccinations in the late 1990s-early 2000s. A catch-up immunisation campaign was successful, but annual vaccine coverage has been decreasing slowly since 2013/14 and measles transmission was re-established in the UK in 2018. The Committee accepted the submissions of Ms Hartley that a professional pharmacist sharing misleading information about vaccines could have, or contribute to, a significant adverse impact on public health.

77. The NHS guidance on "Why vaccination is important" explains that vaccines are important to protect children from "*serious and potentially deadly diseases*" as well as protecting "*other people in your family and community – by helping to stop diseases spreading to people who cannot have vaccines, such as babies too young to be vaccinated and those who are too ill to be vaccinated*". This guidance highlights the gravity of the departures from the Standards referred to above, in particular the risk to Patient A if she had relied on the information which the Registrant gave her, as well as the wider risks to the most vulnerable members of the community.

78. The Committee had found that the Registrant made a series of comments which were entirely contrary to accepted and established science in relation to the condition. She told Patient A that autism isn't life-long, you can "de-tox" or take vitamins, and that it is caused by vaccinations. This information was unsolicited, and understandably, it made Patient A feel both upset and angry. In the Committee's view, sharing and spreading misinformation of this sort constituted a fundamental departure from evidence-based, accepted scientific research and could contribute to a significant risk to public safety.

79. The Committee was in no doubt that the Registrant abused her position of trust as a health care professional, and exceeded the limits of her knowledge and skills when purporting to provide advice in relation to the MMR vaccine and advice relating to autism. Her conduct fell below what is to be expected of a registered health care professional, and would be considered deplorable by her fellow professionals.

80. For the reasons above, the Committee is satisfied that the ground of misconduct is found proved.

The Committee's Decision on Impairment

81. Having found misconduct proved, the Committee went on to consider whether the Registrant's fitness to practise is currently impaired. Rule 5 of the Rules sets out the criteria which the Committee must consider when deciding, in the case of any Registrant, whether or not the requirements as to fitness to practise are met.

82. Rule 5(2) of the Rules states:

"In relation to evidence about the conduct or behaviour of the Registrant which might cast doubt on whether the requirement as to fitness to practise are met in

relation to the registrant, the Committee must have regard to whether or not that conduct or behaviour –

(a) Presents an actual or potential risk to patients or to the public;

(b) Has brought, or might bring, the profession of pharmacy into disrepute;

(c) Has breached one of the fundamental principles of the profession of pharmacy; or

(d) Shows that the integrity of the registrant can no longer be relied upon."

83. Guidance on this issue, (echoed the Council's revised Guidance (2024) at Paragraph 2.15), was set out by Mr Justice Silber in *Cohen v General Medical Council [2008]* EWHC 581 (Admin) at paragraph 65:

"*It must be highly relevant in determining if a [registrant's] fitness to practise is impaired that first his or her conduct that led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated".*

84. The Committee was of the view that the misconduct it had found proved suggested that there may be a cause for concern in relation to the Registrant's attitude to vaccinations and to autism. The Registrant considered it appropriate at the time to disseminate misinformation about the MMR vaccination and autism. She should have known, particularly given that she was a health care professional, that what she shared was discredited by health experts and by science. As set out in the DHSC Guidance, the misinformation has increased the incidence of measles in the population due to reduced uptake of MMR vaccinations in recent decades. Her own explanation for writing and providing the notes on the prescription could itself have suggested a derogation of her responsibility to act in the best interests of patients. However this Committee has preferred the version of events of Patient A, that is, that the Registrant made the comments as alleged, and wrote the note, with the intention of providing what she may have thought was helpful advice to Patient A. In fact, it could have been exceedingly harmful.

85. Applying the considerations set out in the case of ***Cohen***, the Committee is of the view that such an attitudinal issue may be difficult to remediate, but it would not, in the Committee's view, be impossible.

86. As for whether the Registrant has, in fact, remediated her conduct, the Committee carefully considered the evidence provided by the Registrant in relation to current impairment. It took into account that the Registrant was a pharmacist who had been qualified for many years, with no previous regulatory concerns raised against her. It also took into account that the Registrant has continued to work as a locum since the events in question and there have been no further concerns raised. She had stated that since the incident she has been "very guarded in discussing any matters with patients and now limit[s her] conversation solely to the issues/matters giving rise to their attendance at the Pharmacy".

87. She had provided a number of positive testimonials from pharmacy and medical colleagues and line managers, patients and friends, many of whom had known and/or worked alongside her for several years. They praised her clinical skills and knowledge, her kindness, her diligence, and her empathetic manner of communicating. Indeed, Mr Tailor, who had attended the hearing to give evidence on behalf of the Council, had also provided a positive testimonial on her behalf and told the Committee how helpful she was to him in her role as a locum at the Pharmacy, during the Covid pandemic and since.

88. However, none of the referees mentioned anything about the Registrant's views or beliefs about vaccines, the MMR vaccine in particular, or her views beliefs about autism. They did not therefore assist the Committee in determining whether the Registrant had remediated her misconduct, or her attitude to vaccines and to autism, since the event in question.

89. The Registrant had provided evidence that she however the Committee placed little weight on this, since the Particulars of Allegation related to her conduct in relation to Patient A, the MMR vaccine and comments she made about autism.

90. The Committee also noted the evidence of some training online about vaccinations and evidence of receiving 80% in a test about communication skills. The Registrant provided no personal reflections about what she had learned from either of these, in the absence of which the Committee could not assess whether they had been of any relevance to the misconduct or whether they had contributed to remediation.

91. Turning to the Registrant's "reflective essay", the Committee noted that it set out in a detailed structure some of the concerns which might be raised in a situation which

"involves a patient being told, potentially by a friend, social media, or a misinformed healthcare practitioner, that the MMR vaccine is unsafe and causes autism".

92. However, after careful consideration of the document, the Committee was of the view that it amounted to no more than a high-level and generalised rehearsal of some issues which could arise, in a general "situation" of misinformation being given to "a patient". There was nothing contained within the essay which would reassure the Committee that this Registrant had in fact genuinely reflected on the concerns about her conduct which were referred to the Council, or adapted all of the information contained within the "essay" to the particular circumstances of those concerns.

93. The "reflective essay" failed, in the Committee's view, to demonstrate any genuine insight into the effect of her conduct on Patient A Nor did the Registrant express any remorse for her conduct.

94. The Committee concluded that despite the generalities contained within the Registrant's "reflective essay", there was no significant evidence before it as to her current personal views or beliefs about the MMR vaccine, her views or beliefs about autism, and her understanding of the limits of her professional role as a pharmacist in relation to those subjects.

95. The views of the people/organisations which she wrote on the prescription paper, regarding the alleged connection between the use of the MMR vaccine and autism, have been conclusively and very publicly discredited as flying in the face of evidence-based, accepted scientific research. The Committee's concern was that a pharmacist, as a trusted professional, sharing these names and some details of what they say, could appear to be endorsing their views, with the consequent risk to the health of anyone who relied on the pharmacist's expertise.

96. Furthermore, in the absence of any personal and genuine reflection from the Registrant as to what she has learned from the training she took in vaccinations and the practice test in communication skills, the Committee has no evidence before it that she has taken any genuine or considered steps to remedy the attitudinal issues which lay behind her misconduct.

97. Taking all of the above into account, the Committee does not consider, on the basis of the evidence before it, that the Registrant has remedied her conduct. It is not persuaded that her conduct is highly unlikely to be repeated.

98. The Committee next considered Rule 5(2) of the Rules. It accepts the submissions of Ms Hartley in that (a) the Registrant currently presents an actual or potential risk to patients or to the public; (b) she has brought the profession of pharmacy into disrepute; (c) she breached a fundamental principle of the profession of pharmacy, that is, not to share or disseminate health information which is contrary to DHSC guidance, evidence-based and scientifically accepted.

99. The Committee therefore is of the view that the Registrant's fitness to practise is currently impaired on the personal component.

100. Turning to the wider public interest, the Committee bore in mind the case of *CHRE v NMC and Grant* [2011] EWHC 927 (Admin) in which it was said:

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

101. The Committee is of the view that in a case as serious as this, where the Committee has found a current risk of repetition and therefore of harm to the public, the need to uphold professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances of this case.

102. The Committee therefore finds that the Registrant's fitness to practise is currently impaired, both on the personal component, and also on the public component, that is, in order to send a message to the profession and to the wider public, to maintain professional standards, and to uphold public confidence in the profession and in the regulator.

Decision on Outcome

103. Having found impairment, the Committee went on to consider the appropriate outcome.

104. The Committee's powers in relation to sanction are set out in Article 54(2) of the Pharmacy Order 2010.

105. Article 54(2) of the Order provides:

> *"If the Fitness to Practise Committee determines that the person concerned's fitness to practise is impaired, it may–*
>
> a. *give a warning to the person concerned in connection with any matter arising out of or related to the allegation and give a direction that details of the warning must be recorded in the person concerned's entry in the register,*
> b. *give advice to any other person or other body involved in the investigation of the allegation on any issue arising out of or related to the allegation;*
> c. *give a direction that the person concerned be removed from the register;*
> d. *give a direction that the entry in the Register of the person concerned be suspended, for such period not exceeding 12 months as may be specified in the directions; or*
> e. *give a direction that the entry in the Register person of the person concerned be conditional upon that person complying, during such period not exceeding 3 years as may be specified in the direction, with such requirements specified in the direction as the Committee thinks fit to impose for the protection of the public or otherwise in the public interest or in the interest of the person concerned."*

106. The Committee may also make no order.

107. The Committee was aware that it should consider the available outcomes in ascending order from the least restrictive, taking no action, to the most restrictive, removal from the register, in order to identify the appropriate and proportionate outcome that meets the circumstances of this case. It bore in mind that the purpose of the outcome is not to be punitive, though an outcome may in fact have a punitive effect. The purpose of the outcome is to meet the overarching objectives of regulation, namely the protection of the public, the maintenance of public

confidence and to promote and uphold professional standards. The Committee is therefore entitled to give greater weight to the public interest over the Registrant's interests.

108. The Committee had regard to the GPhC's guidance, entitled: Good decision making: Fitness to practise hearings and outcomes guidance (March 2024), ("the Good decision making Guidance") which reminds the Committee that it must consider the full range of outcomes.

Submissions

109. Ms Hartley referred the Committee to her skeleton argument. She referred to the case of Bolton v Law Society (1994) 1 WLR 512, in which it was said: "The reputation of the profession is more important that the fortunes of any individual member. Membership of a profession brings many benefits, but that is part of the price; and to the case of R (on the application of Darren Williams) v Police Appeals Tribunal [2016] EWHC 2708 (Admin), which considered personal mitigation, concluding that this is of secondary importance to the purpose of ensuring public confidence in a profession. Ms Hartley submitted that in regulatory proceedings matters of personal mitigation are less relevant than, for example, in criminal proceedings, because the purpose of the former is not to punish.

110. Ms Hartley submitted that the appropriate and proportionate sanction would be a suspension for a period of nine months, which, she submitted, was necessary to highlight that the misconduct was unacceptable and unbefitting of a member of the pharmacy profession; and that public confidence in the profession could not be maintained by a lesser sanction.

The Committee's Decision

111. The Committee had regard to the relevant law and to the Council's 'Good decision making: Fitness to practise hearings and outcomes guidance (March 2024)' ("the Good decision making guidance"), to inform its decision. It took into account the submissions made by Ms Hartley and all the documentation it had been provided by both the Council and the Registrant.

112. The Committee first considered what, if any, aggravating and mitigating factors there may be.

113. The Committee identified the following aggravating factors:

- The Registrant abused her professional position as a trusted healthcare professional;
- She displayed a fundamental disregard for current scientific evidence, as a result of her personal beliefs which were based on misinformation in relation to the MMR vaccine and autism, and in particular she should have known that the information she wrote and gave to Patient A was contrary to the guidance of the DHSC and the NHS;
- Her misconduct could have had a potentially adverse impact on Patient A, and on wider public safety;

114. The Committee identified the following mitigating factors:

- The Registrant's misconduct appears to have been a one-off incident;
- The Registrant is of previous good character and has no previous Fitness to Practise concerns against her;

- Whilst Patient A experienced distress at the time, there is no evidence of any lasting or serious harm to her**.**
- The Registrant had provided a substantial number of positive testimonials in relation both to her standard of professional practice and to her good character, demonstrating that she is very highly regarded by her colleagues and her friends.

115. The Committee next turned to consider the sanctions available to it in ascending order.

116. Take no Action: The Committee first considered whether it would be appropriate to take no action, which it may do where it has found that there is no risk to the public or need to decide on a different outcome, however it was of the view that this outcome would not protect the public nor would it be sufficient to reflect the seriousness of the Registrant's misconduct, and uphold and maintain the wider public interest.

117. Warning: The Committee next considered whether issuing a warning would be appropriate, but it decided that a warning would not be appropriate for the same reasons as above, namely that a warning would not protect the public nor sufficiently mark the public interest.

118. Conditions of Practice: The Committee next considered whether to impose conditions of practice. The Council's Good decision making guidance states that conditions may be appropriate where there is evidence of poor performance, or significant shortcomings in a professional's practice, but the Committee is satisfied that the professional may respond positively to retraining and supervision; and where there is not a significant risk posed to the public by the imposition of conditions.

119. The Committee determined that conditions would not be appropriate or relevant in this case. There were no concerns in relation to the Registrant's clinical skills and although the conduct took place whilst she was at work, the Committee did not consider that it could formulate workable conditions to safeguard against the Registrant repeating her conduct during interactions with patients. In any case, the Committee considered that an order for conditions would not be sufficient to mark the wider public interest, so as to uphold professional standards, and maintain public confidence in the profession and the regulator.

120. Suspension Order: The Committee next considered whether suspension would be a proportionate sanction. It bore in mind that Ms Hartley had submitted on behalf of the Council that suspension for a period of nine months would be the appropriate and proportionate outcome in this case. The Committee carefully considered the Council's Good decision making guidance which indicates that suspension may be appropriate where:

> *"The Committee considers that a warning or conditions are not sufficient to deal with any risk to patient safety or to protect the public, or would undermine public confidence. When it is necessary to highlight to the profession and the public that the conduct of the professional is unacceptable and unbefitting a member of the pharmacy profession. Also when public confidence in the profession demands no lesser outcome".*

121. The Committee took into account that the Council's Good decision making guidance states at paragraph 5.7 and 5.8 that in reaching a decision on what outcome to impose, the Committee should give appropriate weight to the wider public interest. The Committee is entitled to give greater weight to the public interest, than to the consequences for the professional. Even if an outcome will have a punitive effect, it may still be appropriate.

122. The Committee was satisfied that the public would be protected from any risk of harm whilst the Registrant was suspended from the register. It therefore turned to consider whether a suspension would be adequate and proportionate to maintain public confidence in the profession and proper standards of behaviour.

123. The Committee took into account all of the aggravating and mitigating factors of the case which it had identified. It bore in mind that whilst the Registrant's sharing of misinformation relating to the MMR vaccine and autism could have risked serious harm to Patient A,and to the wider public, the evidence before it was that this was an isolated occasion which did not, in fact, result in serious harm. The Registrant had provided numerous positive testimonials in relation not only to her clinical skills and knowledge but also to her character: she was said to be empathetic, kind and sensitive, and to have a strong work ethic, amongst other positive qualities.

124. The Committee bore in mind in particular that Mr Tailor, the owner and Superintendent of the Pharmacy where the event took place, who had attended as a witness for the Council, had also provided a positive testimonial in which he said:

"I can confidently vouch for her exceptional character, professionalism, and dedication to her pharmacy profession. She possesses a genuine kindness and compassion that radiates trough her interactions with others…a remarkable ability to empathise with people from all walks of life, treating everyone with respect and dignity. [The Registrant] displayed impeccable leadership during the COVID pandemic….and wavering commitment to doing what is right. She upholds a strong moral compass in all aspects of life…someone I can count on anytime".

Mr Tailor repeated much the same to the Committee when giving oral evidence. The Committee bore in mind that there is a public interest in allowing able pharmacists to remain in practice.

125. The Committee also bore in mind that Patient A had told the Committee that she thought the Registrant's intention when she gave her the information was to be kind and helpful.

126. After careful consideration of its findings, and of the submissions on behalf of the Council, the Committee concluded that a period of four months' suspension, together with a review before the end of that period, would be the appropriate and proportionate outcome in this case. This outcome would, the Committee considered, provide sufficient time for the Registrant to reflect on its findings as set out in this determination, and to provide assurance to a reviewing committee that she has understood the seriousness of the Committee's findings, developed insight into her failings, and is unlikely to repeat them.

127. The Committee was of the view that members of the public, were they to be appraised of all the evidence in this case, would consider this a sufficient and proportionate outcome to mark the gravity of the findings of the Committee and thereby uphold and maintain the wider public interest.

128. The Committee was of the view that a suspension of nine months, as proposed by the Council, would be disproportionately severe given all the circumstances of this case.

129. Removal: Having concluded that a period of suspension would satisfactorily deal with the issues of public protection and public interest which it has identified, the Committee considered whether removal was in fact more appropriate. The Committee took into account that removal is reserved for the most serious conduct. The Sanctions Guidance states that:

> *"Removing a professional's registration is reserved for the most serious conduct. The committee cannot choose this outcome in cases which relate solely to the professional's health. The committee should consider this*

outcome when the professional's behaviour is fundamentally incompatible with being a registered professional".

130. Taking all of the evidence into account, the Committee was of the view that the Registrant's conduct found proved is not fundamentally incompatible with being a registered professional and therefore it would be entirely disproportionate to remove her name from the register.

131. The Committee therefore directs that the entry in the Register of Ms Ravinder Kaur TULSI (WALIA) whose registration number is 2046597, be suspended from the Register for a period of four months.

Review Hearing

132. This suspension will be reviewed before its expiry. The Reviewing Committee would benefit from the following:

- The Registrant's attendance at the review;

- A reflective essay written by the Registrant. This essay should demonstrate that she understands the seriousness of the Committee's findings and has developed insight into the specific failings as outlined in those findings. She should consider both the potential and actual impact upon Patient A of the oral and written information she provided to Patient A, and also the effect on the wider public interest which includes maintaining public confidence in pharmacy, and maintaining proper professional standards and conduct for pharmacy professionals. She should aim in this essay to demonstrate that through this developed understanding and insight, she is unlikely to repeat her misconduct.

- The Registrant's personal written reflections, as part of continuous professional development, in relation to any further training or education which the Registrant

considers is relevant. She may, for example, wish to read and reflect upon the DHSC Guidance on immunisation against infectious disease, and on the NHS guidance available online about Why vaccination is important; and any self-education she undertakes (for example by way of reading scientific articles) about autism. This may also include reflections upon any training she may already have undergone in relation to vaccines and the dangers of misinformation.

133. This concludes the determination.

DECISION ON INTERIM MEASURE

134. Ms Hartley, for the Council, made an application for an interim measure of suspension to be imposed on the Registrant's registration, to take effect pursuant to Article 60 of the Pharmacy Order 2010, pending the coming into force of the Committee's substantive order. She submitted that such an order was necessary, from a risk perspective, to protect the public and was otherwise in the public interest.

135. The Committee carefully considered Ms Huntley's application. It took account of the fact that its decision to order a suspension of the Registrant's name for a period of four months from the Register will not take effect until 28 days after the Registrant is formally notified of the outcome, or until any appeal is concluded.

136. The Committee has found that there remains a risk that the Registrant might repeat her conduct if permitted to return to work unrestricted. It accepts the submissions of Ms Huntley that such an order is necessary in circumstances in which the

Registrant has not yet remediated her conduct.

137. It also considers that members of the public would be concerned if interim measures were not put in place to maintain public protection during the time between today's date and the coming into force of the substantive order of suspension.

138. The Committee hereby orders that the entry of the Registrant in the Register be suspended forthwith, pending the coming into force of the substantive order, as it is necessary for the protection of members of the public and is otherwise in the public interest.