General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

Remote videolink hearing

3-6 August 2026

Registrant name:	Niall Thomas Murray
Registration number:	2033602
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Neville Sorab (Chair) Jignesh Patel (Registrant member) Shaun Donnellan (Lay member)
Committee Secretary:	Ivana Raimundova
Registrant:	Not present and not represented
General Pharmaceutical Council:	Represented by Gareth Thomas, Case Presenter
Facts proved:	1.1, 1.3, 1.4, 2, 3, 4.1, 4.2
Facts proved by admission:	None
Facts not proved:	1.2
Fitness to practise:	Impaired
Outcome:	Suspension – 6 months

Interim measures: 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 **4 September 2026** 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 on the 3 October 2024 whilst working as a Responsible Pharmacist at Superdrug Pharmacy, (Redacted) (the "Pharmacy"):

1. *Failed to provide patient centred care to Patient A in so far as you refused to dispense the patient's prescribed medication:*
    - 1.1. *when it was clinically indicated;*
    - 1.2. *without a clinical reason and/or justification;*
    - 1.3. *without making enquiries or consulting with Patient A's prescriber and/or General Practitioner; and/or*
    - 1.4. *without recording your decision.*
2. *Allowed a junior member of staff to convey your concerns and your decision in 1.2 to Patient A.*
3. *Your conduct at paragraph 1 was discriminatory.*
4. *You communicated to Patient A, in a public place, by telling her the following contrary to NHS guidance:*
    - 4.1. *that you do not agree with the Covid vaccine; and/or*
    - 4.2. *would promote people not taking it.*

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

Documentation

Document 1- Council hearing bundle

Document 2- Council skeleton

Document 3- Council bundle Appendix Exhibit CS01

Document 4- Proof of Service Bundle

Document 5- Proceeding in Absence Bundle

Document 6- *GMC v Adeogba [2016] EWCA Civ 162*

Document 7- Notice from the Sheffield Gender Identity Clinic dated August 2024 and similar clinics

Document 8- BNF pages from 2024-2025 Edition

Determination

Introduction

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

2. The 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. Outcome – the Committee considers what, if any, outcome 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 18 June 2026 from the Council headed "*Notice of Hearing*" sent by email to Mr Murray ("the Registrant"). The Notice of Hearing was sent more than 28-days prior to the commencement of the hearing, stated the date, time and venue of the hearing, and also contained the finalised particulars of the allegation. The Notice of Hearing was sent by mail to the address provided by the Registrant on the Council's register. The Committee has seen proof of receipt by the Registrant on 20 June 2026. The Committee was satisfied that there had been good service of the Notice in accordance with Rules 3 and 16.

Application to proceed in the absence of the Registrant

7. The Registrant was not in attendance at this hearing, nor was a representative attending on his behalf. The Committee heard submissions from Mr Thomas, on behalf of the Council, to proceed in the absence of the Registrant under Rule 25, on the basis that:

a. There has been good service;

b. The Registrant was aware of the hearing. He has said that he would consider attending should he be compensated for a loss of earnings. When the Registrant was told that this was unlikely, he replied to an email from the Council on 8 July

2026 stating: "*Further to the last communication requesting my response within 14 days. I am replying to say I will NOY (sic.) be attending hearing*";

c. No adjournment has been sought by the Registrant and, in any case, an adjournment would not secure the attendance of the Registrant;

d. It is in the public interest to proceed in the absence of the Registrant; and

e. Witnesses have been warned and are waiting to give evidence.

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

a. The Committee has found good service of the Notice;

b. The Registrant was aware of the hearing and has explicitly stated that he would not be attending this hearing;

c. There was no information to suggest an adjournment would result in the Registrant's attendance in future;

d. Although there is a disadvantage to the Registrant caused by his absence, this disadvantage can be mitigated by the Committee ensuring that the hearing is as fair as the circumstances permit;

e. There is a public interest in the expeditious disposal of the case; and

f. Witnesses have been warned and are waiting to give evidence. It is not known when in the future it would be convenient for all parties and the witnesses to attend.

Application to admit further evidence

9. On behalf of the Council, Mr Thomas made an application to admit the following evidence:

a. Email from Patient A to case officer confirming certain details dated 23 July 2026;

b. Email from Superdrug Superintendent dated 27 July 2026;

c. Full copy of Prescription Processing SOP dated July 2024;

d. British National Formulary ("BNF") pages from 2024-2025 Edition (replacement);

e. Telephone note between the Council and Dr F dated 28 October 2025;

f. Telephone note between the Council and CS dated 5 December 2025;

g. Notice from the Sheffield Gender Identity Clinic dated August 2024 and similar clinics; and

h. Feminising Hormone Treatment for Adults dated July 2022.

10. Mr Thomas made the application on the basis that:

a. Email from Patient A to case officer confirming certain details dated 23 July 2026. This document confirms that the Patient A does not have the original prescription as she went to another pharmacy, and confirmation that the prescription is an NHS prescription.

b. Email from Superdrug Superintendent dated 27 July 2026. This is information which sets out that if the Registrant had an issue with an area of practice, he should raise this in advance with Superdrug. The Registrant provided an objection to Superdrug for dispensing the emergency hormonal contraception. This objection was logged on 3 October 2024, but after the time of the allegations. This document shows there was an opportunity for the Registrant to raise concerns about dispensing to trans-people, which was not taken. This information was not available until 27 July 2026.

c. Full copy of Prescription Processing SOP dated July 2024. This is a full copy of a document that the Committee already has. There is no prejudice caused as the Registrant would be aware of this document from his time at the Pharmacy.

d. BNF pages from 2024-2025 Edition (replacement). This is the BNF guidance from the time of the alleged misconduct. It should replace the existing BNF Guidance the Committee has, which is from 2022.

e. Telephone note between the Council and Dr F dated 28 October 2025. This document sets out that Dr F issued the prescription, following the advice of CS, without expertise in the clinical area.

f. Telephone note between the Council and CS dated 5 December 2025. This document sets out that CS set out the medication that Patient A's GP should prescribe on an ongoing basis.

g. Notice from the Sheffield Gender Identity Clinic dated August 2024 and similar clinics. These are documents from various Gender Identity Clinics setting out an opinion that "*the prescription of progesterone for our trans female clients is not indicated at present.*" This supports a strand of the Registrant's case.

h. Feminising Hormone Treatment for Adults dated July 2022. This was seen and considered by the Council at an early stage of preparation of its case. It does not assist either party and does not materially further the case.

i. The Registrant was sent these documents on 30 July 2026 and they were received by him on 31 July 2026. He has not provided any submissions on them.

11. Rule 18(5) sets out "*Any document which has not been served on the secretary by the end of the period specified in paragraph (3) is, except in exceptional circumstances, not to be admitted into evidence at the hearing.*" The Committee considered:

a. The material subject to the application had not previously been served on the secretary, and therefore falls under Rule 18(5).

b. Email from Patient A to case officer confirming certain details dated 23 July 2026. The Registrant is only recently aware of this document (on 31 July 2026 for a Principal Hearing commencing on 3 August 2026) and has not provided any submissions on it. It is not known what he would do with this document. This information could be available through examination of Patient A. The Committee considered it to be unfair to admit this document and there are no exceptional circumstances to admit this document.

c. Email from Superdrug Superintendent dated 27 July 2026. The Registrant is only recently aware of this document (on 31 July 2026 for a Principal Hearing

commencing on 3 August 2026) and has not provided any submissions on it. The Registrant is not present to provide his explanation on his actions raised by this document. Furthermore, the document does not deal directly with the allegations. The Committee considered it to be unfair to admit this document and there are no exceptional circumstances to admit this document.

d. Full copy of Prescription Processing SOP dated July 2024. No exceptional reason has been provided why this document, which was available at the time the Rule 14 bundle was submitted, was not provided with the Rule 14 bundle. The Committee does not admit this document.

e. BNF pages from 2024-2025 Edition (replacement). The Committee considered there to be exceptional circumstances to admit this document given that this is the BNF guidance from the time of the alleged misconduct. The Committee was previously given BNF Guidance from 2022, which was not the time at which the allegations occurred. The document is relevant and fair to admit as the Registrant would have been aware of the BNF Guidance from 2024-25.

f. Telephone note between the Council and Dr F dated 28 October 2025. No exceptional reason has been provided why this document, which was available at the time the Rule 14 bundle was submitted, was not provided with the Rule 14 bundle. The Committee does not admit this document.

g. Telephone note between the Council and CS dated 5 December 2025. No exceptional reason has been provided why this document, which was available at the time the Rule 14 bundle was submitted, was not provided with the Rule 14 bundle. The Committee does not admit this document.

h. Notice from the Sheffield Gender Identity Clinic dated August 2024 and similar clinics. The Committee considered there to be exceptional circumstances to admit these documents given that these documents are relevant as they go directly to a point raised by the Registrant in his case. It would be fair to admit these documents as the Registrant would not have objected to the admission of these documents.

i. Feminising Hormone Treatment for Adults dated July 2022. There is no exceptional reason to admit this document. The document does not further the case.

12. The Committee affirmed that it was a professional Committee which is able to put out of its mind, for the remainder of the Principal Hearing, the material considered to be inadmissible. On behalf of the Council, Mr Thomas agreed, highlighting that none of the material was a "*smoking gun*".

Background

13. On 3 October 2024, the Registrant was working as a locum pharmacist at a branch of Superdrug (Redacted) (the "Pharmacy"). Patient A is a trans woman who attended the Pharmacy in order to collect a prescription for Progesterone 100mg capsules and Estradot patches. This was a repeat prescription, provided by her GP at the request of her clinician, CS. ***PRIVATE*** This was the first occasion when the Registrant had been on duty when Patient A attended.

14. Patient A initially spoke to the Registrant before waiting some time for the medication to be dispensed. The Registrant did not return to speak to her but instead a trainee dispenser, TS, spoke to Patient A to explain that she could not dispense the medication, but that Patient A could speak with the Registrant.

15. Patient A waited until she could speak to the Registrant. She recorded this conversation. The Registrant informed Patient A that the prescribed medication was for women (i.e. biological women) only and that he would not put his name to the supply. This he attributed to scientific reasoning but he also made reference to personal experience of a relative who de-transitioned after experiencing difficulties. He said that it was nothing personal. Patient A and the Registrant discussed the option for her to take the prescription elsewhere. The Registrant told Patient A his name and wrote for her.

16. Patient A subsequently made a complaint to the Pharmacy manager and the Council.

17. The Registrant provided a response to the Council's investigation, which is consistent with the explanation he gave to Patient A during the incident. He states that the Summary of Product Characteristics and BNF showed that the medication was not indicated other than in women (i.e. as part of hormone replacement therapy for post-menopausal women). He implies that he had a sound clinical justification for refusing to dispense. He also cites the well-known Cass review. He disputes that he "*refused*" to dispense *per se*, preferring to say that he would not be involved in the supply but he accepts that no note was made in the Patient's PMR, which he says was remiss.

Evidence

18. The Committee received, amongst other evidence, the following:

    a. Witness statements from:

        i. Patient A

        ii. TS

        iii. CS

        iv. SE

    b. The video recording between Patient A and the Registrant.

    c. Transcripts of the video recording between Patient A and the Registrant.

    d. Prescriptions of Patient A.

    e. Concern Form from Patient A.

    f. Council Guidance.

    g. Registrant's submission to Investigating Committee.

19. Patient A provided the following evidence:

a. At around 10.30am on 3 October 2024, she went into the Pharmacy, which was her nominated pharmacy, in order to collect her repeat prescription of progesterone and Estradot which her General Practitioner ("GP") had prescribed her. She had been prescribed these medications for approximately a year and a half. The prescription was from her GP, although the direction for the prescription came from her Consultant. Patient A's GP and Consultant had a shared care agreement concerning Patient A.

b. ***PRIVATE***

c. She initially spoke with the Registrant to ask if she could collect her prescription. She handed her prescription and provided her name. the prefix "*Mx*" was on the prescription. She was prescribed 60 capsules of progesterone 100mg and 16 patches of Estradot 100microgams. The Registrant did not ask her any questions about her medical history or situation. Consequently, she assumed that he made his decision that she was trans based upon appearances. She did not want the Registrant to prejudge other patients.

d. The Registrant went behind the counter and responded politely that he would be a few minutes. She waited around five to ten minutes on the chair in front of the counter. After that period of time, an assistant and/or trainee pharmacist, came up to the counter and asked if she could come back another day.

e. The trainee pharmacist explained that they had the medications in stock but needed to put them together and dispense them. She said that she would struggle to make it in for the next two weeks to which she said, "*we can do it now, it will just be a 20 minute wait*" or words to that effect. She confirmed that was fine. She also received a text message that the medication was in stock at the Pharmacy.

f. She waited approximately 15 minutes before the trainee came round the counter and handed back the prescription. The trainee was visibly distressed and said that Patient A could not have her medication. The trainee said, "*I can't dispense this for you because my manager isn't allowing me to give it to you*" or words to that effect.

g. When trying to explain things further, she could tell that the trainee was becoming quite emotional and was getting more and more distressed, struggling to explain why Patient A could not have the medication. The trainee started crying so Patient A offered to hug her, but she said no. The trainee said that Patient A could speak with the Registrant if she wanted to. She felt it was cowardly for the Registrant to get his junior to speak with her.

h. Patient A decided to speak with the Registrant as she was very angry at him for putting that responsibility on the trainee. She returned to the queue and waited in line to speak with the Registrant who was serving customers.

i. After 10 minutes later, she reached the front of the queue and asked the Registrant why he had refused to dispense her prescribed medication. In response, the Registrant offered to speak with her to the side, away from other customers. She remained neutral when speaking with the Registrant. She did not want to show any emotions towards the situation as she wanted to hear what the Registrant had to say first. Although she was angry, she was not visibly angry or ever showed her frustration.

j. She decided to record the conversation as she felt the Registrant had asked if they could step to the side so he could try to explain or excuse himself. She also suspected that he did not want the other customers to hear why he had refused to dispense her medication. The Registrant did not know that she was recording because she held her phone close to her chest.

k. She recorded the conversation as she suspected the Registrant would provide reasons why he would not dispense the medication, and would refuse to dispense against guidance. She also wanted to review these reasons when she was less distressed. She was distressed as the Registrant's junior was distressed and that she faced discrimination.

l. In brief, the Registrant explained that the medicine was not covered by the licensing arrangements within the BNF, and if anything, deviates from that. She asked him whether his view was that these medications should not be prescribed to transgender people, to which he replied "*yes*". She then asked the Registrant if

this was a belief that he held. The Registrant confirmed that it was "*a clinical and scientific reasoning*". The Registrant expressed that he would not put his clinical signature to the prescription.

m. The Registrant said he did not think it was appropriate in the long term and that it was not researched. He said he was not going to change his course of thinking. Although the Registrant was not unpleasant, he was very defensive. Almost stuck in his own ways. She asked for the Registrant's name, to which he said was "*Niall Murray*". He then wrote his name for her.

n. The Registrant also said that he was one of those people who had not received the coronavirus vaccine and prompted people not to do so. It seemed that the Registrant was preventing people from receiving the vaccine.

o. She mentioned that the Registrant had caused his colleague, referring to the trainee, quite a bit of distress. She was crying and was really upset about the situation. In response, the Registrant said, she had caused him distress by arriving late and mentioned that he had people queuing.

p. She ended the conversation by informing the Registrant that she had recorded their conversation and would be making a formal complaint against him. At that point, the Registrant became very upset. She felt it was because he realised, he probably said a few things he should not have said.

q. The conversation left her shocked and in disbelief. She could not believe that a pharmacist could refuse my medication and have a say with what she puts into or does with her body.

r. She has now changed her pharmacy to an online pharmacy so that she can receive her medication without judgement.

s. She did not get into a debate with the Registrant about the COVID vaccine.

20. TS provided the following evidence:

a. At the time of the allegations, she was a trainee dispenser at the Pharmacy.

b. 3 October 2024 was the first time she had met or worked with the Registrant.

c. When she arrived to work around 10.30 AM, the Pharmacy was quite busy, and she was trying to manage the flow of patients that were coming in and those already waiting. Patient A had been waiting for a while, and the prescription was almost ready. She had labelled the items on the prescription and signed off as the dispenser; she only needed the Registrant to do the regular pharmacist checks and sign off. When she asked the Registrant to sign it off, he refused, stating that he was not willing to do so because he did not believe in it. He said there was no science behind it and asked her to provide evidence to support it, challenging her on the matter. In the context of the situation, TS considered the Registrant did not believe in transitioning.

d. She asked him if he was unwilling to dispense the item at all, and he confirmed that he would not, reiterating that he did not believe in doing so. She recognised the patient as a regular customer and was aware that they had never previously encountered issues with pharmacists dispensing their medication. She questioned why he was refusing and was shocked to encounter such a situation, as she had worked with many locum pharmacists before and none of them had done this before.

e. Additionally, the Registrant expressed that he was also unwilling to provide emergency contraception over the counter.

f. She knew that she had to speak to Patient A and inform them that they would need to return another day or visit another pharmacy. She had to speak to Patient A as the Registrant was too busy with other matters. Patient A informed her they would not be able to come back on a different day so she had to return their prescription to them so they could get it dispensed at a nearby pharmacy. Whilst speaking to Patient A, she became visibly upset, not just because of this particular incident but also due to the Pharmacy being busy and other factors of the morning. She considered that the Pharmacy should not have denied a patient their medication when it was available in stock and had been deemed suitable on previous occasions.

g. She informed Patient A that the Registrant's details were available should they wish to note them down, and then she briefly excused herself. When she returned, she saw that Patient A was waiting to speak with the Registrant, but she was not part of the conversation.

h. She had no conversation with the Registrant regarding HRT or hormones in general.

i. Later in the afternoon, she informed management that the Registrant refused medication to a patient.

21. CS provided the following evidence:

Patient A

a. He first met Patient A in November 2022. ***PRIVATE*** Patient A had been taking oestradiol patches 100mcg twice weekly, progesterone 200mg at night and spironolactone 100mg once daily. Although Patient A seemed to have achieved good results, there had been no professional guidance or monitoring of her hormone therapy.

b. ***PRIVATE*** Patient A asked whether she would be happy to supervise her hormonal treatment. He confirmed that he was happy to provide advice and guidance, and have oversight following her operation.

c. On 6 February 2023, he informed Patient A's GP that he would be happy to supervise her feminising hormone therapy within the framework of a shared care agreement. He explained that he would prepare a care agreement setting out how future shared monitoring of the patient's treatment between her GP and me could be managed. Patient A was transferred back into the care of her GP. At a later date, he sent a letter to Patient A's GP detailing her treatment plan and instructing them that Patient A should be prescribed oestrogen and progesterone. He informed Patient A's GP that he would review and adjust the dosage of medicines as required.

d. He considered Patient A to be intelligent and well informed to make her own decisions. He considered that progesterone worked for her and she responded well, clinically, to the treatment. He was happy with her results achieved, even if she was not being properly supervised.

Concern

e. He has been asked whether progesterone and Estradot patches were prescribed off-label i.e. outside their licensed indications. Estradot patches are slow release of oestrogen and are primarily used in biological female women for hormone replace therapy in menopause. Prescribing these hormones to Patient A would be off-label as prescription to transgender patients would not be the principal purpose of the medication. However, such medication would constitute standard treatment for transgender patients as per the WPATH guidelines. It is absolutely necessary to replace the sex hormone after the removal of both testes.

f. In this case, Patient A had bilateral orchiectomy and scrotum removal. As such, the patient needed regular treatment and monitoring of the doses. There would not have been a significant change in the dose. In his experience, the doses of Patient A's feminising hormone treatment usually do not require significant adjustment postoperatively. In this case, Patient A had been taking oestrogen for at least a year and would have known what dose worked well for them. Patient A was likely within the target range of around 400-600pmol/L. It would have been clear what needed to be achieved.

g. There would have been no clinical reason for the Registrant to refuse Patient A's medication. In fact, not taking oestrogen would lead to osteoporosis, cognitive issues and muscle waste. The side effects of taking these hormones are minimal. Especially for a patient who has been castrated. It is crucial for transgender patients to take the hormones to ensure they have no contraindications, are healthy and have no comorbidities.

h. If a pharmacist is uncertain about a prescription, there should be a discussion between healthcare colleagues and not a matter which should be discussed with the patient. A telephone call or an email between healthcare professionals

should be appropriate. It can take time to dispense medication and Patient A could have returned the following day should there be an issue with the medication prescribed.

22. Although the Registrant was not present or was represented, on 7 April 2025, he provided the following letter in response to the allegations:

> "*I am writing in response to the allegations made against me concerning the prescription validation of two medications—progesterone and Estradot—on 3rd October 2024. Thank you for providing me with an opportunity to respond to the allegation against me. I understand the concerns raised and would like to take the opportunity to clarify the circumstances surrounding the incident.*
>
> *Firstly, I wish to emphasise that I did not refuse the prescription; rather, I made a professional decision to decline involvement in the supply of the medications. On the day in question, I reviewed the prescription which included two hormonal medications, progesterone and Estradot. These medications are listed in both the Special Product Characteristics (SPC) and the British National Formulary (BNF) for use in female patients only, with no references or addenda suggesting alternative uses for male patients.*
>
> *As the recipient of the prescription was male, and based on my professional knowledge of the SPC and BNF entries for these medications (as of October 2024), I determined that it was clinically inappropriate for me to be involved in the supply.*
>
> *I am fully aware of the complexities surrounding the use of feminising/masculinising hormones, and I am familiar with the findings of the Cass Report of August 2023, which underscores the lack of definitive scientific evidence for the use of these treatments in non-female patients. This further informed my decision to exercise professional caution.*

Additionally, I must clarify that no record was made on the day in question in the Patient Medication Record (PMR) due to the immediate nature of the decision. The action that could have been undertaken on this occasion was to complete an entry on the PMR. This was remiss on my part.

The prescription was brought to my attention for pharmacist validation, and given the clinical concerns, I opted not to proceed with the supply of the medications at that time.

Furthermore, I did not contact the prescribing GP on this occasion. In the past, I have raised similar concerns regarding prescriptions of this nature with the GP and nurse on four separate occasions. Each time, I received different responses, none of which provided new information or altered my clinical judgment or subsequent actions.

I hope this explanation helps to clarify the circumstances and the rationale for my decision. My actions were made with the intent of prioritising patient safety, adhering to clinical guidelines, and using my professional judgment based on available evidence. I am committed to ensuring that all my actions align with the ethical and professional standards required of me as a pharmacist."

Second Application to amend the particulars of allegation

23. Rule 41 sets out in pertinent part:

> *(1) At a principal hearing, at any stage before making its findings of fact, the Committee may of its own motion or following an application of one of the parties, amend the particulars of the allegation set out in the Notice of Hearing, unless it is of the view that the required amendment would prejudice the fairness of the proceedings.*
>
> *(2) Before making any amendment under paragraph (1), the Committee must consider—*

(a) any representations from the parties (where present); and

(b) in the case of a hearing in relation to a health allegation, the advice of the legal and clinical advisers."

24. Allegations 1 and 4 originally read:

1. "Failed to provide patient centred care to Patient A in so far as you refused to dispense the patient's prescribed medication:

1.1. when it was clinically indicated;

1.2. without a clinical reason and/or justification;

1.3. without making enquiries or consulting with Patient A's prescriber and/or General Practitioner; and/or

1.4. without recording your decision.

4. You communicated to Patient A, in a public place, by telling her the following contrary to NHS guidance:

4.1. that you do not agree with the Covid vaccine; and/or

4.2. would promote people not taking it."

25. On behalf of the Council, Mr Thomas presented the case on a disjunctive basis – i.e. that each sub-allegation of allegations 1 and 4 are not reliant on each other for the entire allegation to be proved. The Committee considered that allegations 1 and 4, as originally drafted, could be read so that all parts of each allegation need to be proved for the allegation to be proved. Consequently, for the purposes of clarity, especially in the absence of the Registrant, it would be fairer for the allegations to reflect how the case was presented.

26. Consequently, under Rule 41, the Committee proposed the following amendments to allegations 1 and 4 as follows (additions in underline and removals in strikethrough):

"*1.3. without making enquiries or consulting with Patient A's prescriber and/or General Practitioner; and/or*

4.2. that you do not agree with the Covid vaccine; and/or"

27. On behalf of the Council, Mr Thomas did not object to the proposed amendment for the reasons set out by the Committee.

28. The Registrant was not present or represented to submit on the proposed amendment to the allegations.

29. Consequently, the Committee amended the allegations on the basis that:

    a. The application has been made at the Principal Hearing, before the Committee has found on facts.

    b. The Committee has heard from parties present at the Principal Hearing.

    c. The amendments would not prejudice the proceedings, but rather make the proceedings fairer as the allegations reflect how the case was presented.

Decision on Facts

30. The Chair provided legal advice on how the Committee should examine the evidence and considerations on discrimination.

31. The Committee considered each allegation in turn.

Allegation 1: You failed to provide patient centred care to Patient A in so far as you refused to dispense the patient's prescribed medication:

Refusal to dispense Patient A's prescribed medication

32. In the stem of allegation 1, the Committee considered whether the Registrant refused to dispense Patient A's prescribed medication.

33. The Committee considered the following evidence on the issue of whether the Registrant refused to dispense medication to Patient A:

    a. The Committee has seen a photo of a repeat medication form which shows that Patient A's list of medication was 60 capsules of progesterone 100mg and 16

patches of Estradot 100microgams. The Committee also saw Patient A's prescription in the video recorded by Patient A.

b. The recording of the contemporaneous conversation between Patient A and the Registrant set out that the Registrant said: "*I won't put my clinical signature to it.*"

c. TS who provided evidence that the Registrant refused to sign off the prescription.

d. Patient A said that, at the time of attempting to obtain the medication from the Pharmacy, TS told her: "*I can't dispense this for you because my manager isn't allowing me to give it to you*" or words to that effect.

e. The Registrant provided evidence that:

   i. "*I wish to emphasise that I did not refuse the prescription; rather, I made a professional decision to decline involvement in the supply of the medications.*"

   ii. "*The prescription was brought to my attention for pharmacist validation, and given the clinical concerns, I opted not to proceed with the supply of the medications at that time.*"

34. The Committee found all witnesses who gave live evidence – Patient A, TS and CS – to be credible. On a balance of probabilities, the Committee finds that the Registrant refused to dispense medication to Patient A on the basis that:

a. It has not been contested that the prescription was for Patient A. There is no evidence before the Committee to doubt the authenticity of the prescription.

b. Patient A did not obtain the medication in her prescription from the Pharmacy, where the Registrant was the Responsible Pharmacist.

c. The recording of the contemporaneous conversation between Patient A and the Registrant set out that the Registrant said: "*I won't put my clinical signature to it.*" This evidence is corroborated by:

   i. TS who provided evidence that the Registrant refused to sign off the prescription.

ii. Patient A, who at the time of attempting to obtain the medication from the Pharmacy, said that TS told her: "*I can't dispense this for you because my manager isn't allowing me to give it to you*" or words to that effect.

iii. The Registrant who provided evidence that he "*decline[d] involvement in the supply of the medications*" and "*I opted not to proceed with the supply of the medications at that time.*"

d. Although the Registrant has said that he "*did not refuse the prescription*", the medication was not provided to Patient A because he refused to "*proceed with the supply of the medications at that time.*" Whether he "*opted not to proceed*" or "*decline involvement*", to the Committee, this amounts to a refusal to dispense Patient A's prescribed medication. Patient A did not receive her medication from the Pharmacy.

Patient centred care

35. In the stem of allegation 1, the Committee considered whether the Registrant failed to provide patient centred care. It did so after dealing with the sub-allegations in allegation 1 (see below, paragraphs 39-50). The need to provide patient centred care is stated in the *Standards for Pharmacy Professionals, May 2017*, Standard 1: Pharmacy professionals must provide person-centred care. As set out below, the Registrant refused to dispense the patient's prescribed medication:

a. when it was clinically indicated;

b. without making enquiries or consulting with Patient A's prescriber and/or General Practitioner; and

c. without recording his decision.

36. A pharmacist is required to undertake a clinical check of medicines being dispensed against a prescription. This check is a matter of clinical and professional judgement as to whether the medication including dose and known interactions is appropriate for a patient, or whether the prescriber may have made an error. Properly understood, the clinical check supports patient safety and person-centred care.

37. A pharmacist might have reasons of personal belief or conscience for not wanting to dispense certain types of medication. The Council has issued guidance in this area: "*In practice: Guidance on religion, personal values and beliefs*" (2017). Examples include opponents of abortion and similar procedures not being required to dispense emergency contraception. The Guidance says that certain steps should be taken where a pharmacist might refuse supply for reasons for personal belief. These include informing an employer in advance so that alternative arrangements can be made, clear communication with the Patient, recording of the decision, and in some cases referral to another practitioner.

38. Whilst the Committee considered that the Registrant had a clinical reason or justification to refuse dispensing Patient A's description (see paragraphs 42-44 below), he failed to provide patient-centred care for the following reasons:

    a. The Registrant did not raise his concerns with Patient A's Consultant, prescriber or GP. This would have been in Patient A's best interests if the Registrant had concerns over Patient A's prescription.

    b. Patient A provided evidence that the Registrant did not ask her any questions about her medical history or situation. There is no evidence before the Committee to counter this. Therefore, the Committee considered that the Registrant made no attempt to understand the Patient's individual circumstances or to understand her needs.

    c. The recording of the contemporaneous conversation between Patient A and the Registrant set out that the Registrant said: "*I happen to be related to someone who has de-transitioned … He's now a proponent of saying I've changed for his, for no good reason, ok?*" By relating Patient A's case to that of his relative, the Registrant was not taking each case on its merits, which is not in the best interests of Patient A and providing person-centred care.

    d. The Registrant did not record his decision, which could have assisted Patient A and himself in understanding his thought process when considering Patient A's medication in the future. This was not providing person-centred care.

e. TS provided evidence that the Registrant said there was no science behind it and asked her to provide evidence to support it, challenging her on the matter. In the context of the situation, TS considered the Registrant did not believe in transitioning.

Allegation 1.1: You failed to provide patient centred care to Patient A in so far as you refused to dispense the patient's prescribed medication when it was clinically indicated:

39. The Committee has found that the Registrant refused to dispense Patient A's prescribed medication. It will now consider whether the medication was clinically indicated.

40. The Committee considered the following evidence on the issue of whether the medication was clinically indicated:

a. The Committee has seen a photo of a repeat medication form which shows that Patient A's list of medication was 60 capsules of progesterone 100mg and 16 patches of Estradot 100microgams. The Committee also saw Patient A's prescription in the video recorded by Patient A.

b. CS provided evidence that:

i. Patient A needed regular treatment and monitoring of the doses;

ii. Patient A had been taking oestrogen for at least a year and would have known what dose worked well for them;

iii. There would have been no clinical reason for the Registrant to refuse Patient A's medication; and

iv. It is crucial for transgender patients to take the hormones to ensure they have no contraindications, are healthy and have no comorbidities.

c. Patient A said that she went into the Pharmacy, which was her nominated pharmacy, in order to collect her repeat prescription of progesterone and

Estradot which her GP had prescribed her. She had been prescribed these medications for approximately a year and a half.

41. On a balance of probabilities, the Committee finds that the medication was clinically indicated on the basis that:

    a. The Committee considered that the prescription would not have been issued if it was not clinically indicated.

    b. CS provided evidence that Patient A needed regular hormone treatment to ensure, amongst other things, general health.

    c. Patient A was on a repeat prescription and had been coming to the Pharmacy, as her nominated Pharmacy, for 18 months to collect her prescriptions.

ALLEGATION PROVED

Allegation 1.2: You failed to provide patient centred care to Patient A in so far as you refused to dispense the patient's prescribed medication without a clinical reason and/or justification:

42. The Committee has found that the Registrant refused to dispense Patient A's prescribed medication. It will now consider whether the Registrant refused to dispense the patient's prescribed medication without a clinical reason and/or justification.

43. The Committee considered the following evidence on the issue of whether the Registrant refused to dispense the patient's prescribed medication without a clinical reason and/or justification:

    a. The recording of the contemporaneous conversation between Patient A and the Registrant set out that the Registrant said:

        i. "*Yeah, ok. Yeah, ok. Right, so, that isn't covered by the licensing arrangements within, it's called (indistinct word) National Formulary, ok? … 1 If anything deviates from that, then I won't put my clinical signature to it.*"

ii. "*No, it's, it's a clinical and scientific reasoning I hold.*"

iii. "*So, I'm not about to give some, another drug, for example … At four times the dose … If it's not covered by license, coz then I would be in, in violation of my own erm, scientific reasoning.*"

b. Patient A provided evidence that:

i. The Registrant explained that the medicine was not covered by the licensing arrangements within the BNF, and if anything, deviates from that. She asked him whether his view was that these medications should not be prescribed to transgender people, to which he replied "*yes*". She then asked the Registrant if this was a belief that he held. The Registrant confirmed that it was "*a clinical and scientific reasoning*". The Registrant expressed that he would not put his clinical signature to the prescription; and

ii. The Registrant said he did not think it was appropriate in the long term and that it was not researched. He said he was not going to change his course of thinking.

c. TS provided evidence that the Registrant said there was no science behind it and asked her to provide evidence to support it, challenging her on the matter. In the context of the situation, TS considered the Registrant did not believe in transitioning.

d. The Registrant provided evidence that:

i. "*I made a professional decision to decline involvement in the supply of the medications. On the day in question, I reviewed the prescription which included two hormonal medications, progesterone and Estradot. These medications are listed in both the Special Product Characteristics (SPC) and the British National Formulary (BNF) for use in female patients only, with no references or addenda suggesting alternative uses for male patients.*"

ii. "*I am fully aware of the complexities surrounding the use of feminising/masculinising hormones, and I am familiar with the findings of the Cass Report of August 2023, which underscores the lack of definitive scientific evidence for the use of these treatments in non-female patients. This further informed my decision to exercise professional caution.*"

e. The 2024 BNF Guidelines for Estradot and progesterone.

44. On a balance of probabilities, the Committee finds that the Registrant refused to dispense the patient's prescribed medication with a clinical reason and/or justification. on the basis that:

a. The Registrant provided evidence that he took a professional decision not to supply the medication set out in the prescription as the medication was for cis-female patients, as per BNF and SPC Guidelines. There is no guidance for trans women. Having seen the 2024 BNF Guidelines, the Committee did not see guidance for Estradot and progesterone for trans women.

b. The Registrant has been consistent in his evidence as his written evidence reflects what he told Patient A in the recording of the contemporaneous conversation between Patient A and the Registrant. Patient A's evidence also reflects this is what the Registrant told her at the time of refusing her prescription.

c. TS provided evidence that the Registrant said there was no science behind it and asked her to provide evidence to support it, challenging her on the matter. It is not clear to the Committee what TS meant by "*no science behind it*", as TS provided evidence that, in context of the situation, she considered the Registrant did not believe in transitioning. However, the Committee considered that other evidence demonstrates that there was a clinical reason provided by the Registrant to refuse Patient A's medication.

ALLEGATION NOT PROVED

Allegation 1.3: You failed to provide patient centred care to Patient A in so far as you refused to dispense the patient's prescribed medication without making enquiries or consulting with Patient A's prescriber and/or General Practitioner:

45. The Committee has found that the Registrant refused to dispense Patient A's prescribed medication. It will now consider whether the Registrant did so without making enquiries or consulting with Patient A's prescriber and/or GP.

46. The Committee considered the following evidence on the issue of whether the Registrant refused to dispense Patient A's medication without making enquiries or consulting with Patient A's prescriber and/or GP:

    a. The Registrant provided evidence that he "*did not contact the prescribing GP on this occasion. In the past, I have raised similar concerns regarding prescriptions of this nature with the GP and nurse on four separate occasions. Each time, I received different responses, none of which provided new information or altered my clinical judgment or subsequent actions.*"

47. On a balance of probabilities, the Committee finds that the Registrant refused to dispense Patient A's medication without making enquiries or consulting with Patient A's prescriber and/or GP:

    a. The Committee has not seen any evidence that the Registrant made enquiries with Patient A's prescriber and/or GP concerning Patient A's medication. This is corroborated by the Registrant's evidence. Each patient must be treated on their own merits. Where a pharmacist is concerned about a prescription, they should, on all occasions, raise concerns with the GP or prescriber as this patient could have a specific reason for being prescribed a particular medicine.

ALLEGATION PROVED

Allegation 1.4: You failed to provide patient centred care to Patient A in so far as you refused to dispense the patient's prescribed medication without recording your decision:

48. The Committee has found that the Registrant refused to dispense Patient A's prescribed medication. It will now consider whether the Registrant did so without recording his decision.

49. The Committee considered the following evidence on the issue of whether the Registrant refused to dispense Patient A's medication without recording his decision:

    a. In his written response to the allegations dated 7 April 2025 the Registrant sets out: "*I must clarify that no record was made on the day in question in the Patient Medication Record (PMR) due to the immediate nature of the decision. The action that could have been undertaken on this occasion was to complete an entry on the PMR. This was remiss on my part.*"

    b. The Committee has not been provided any evidence of the Registrant recording his decision in relation to Patient A.

50. Consequently, on a balance of probabilities, the Committee finds that the Registrant refused to dispense Patient A's medication without recording his decision.

ALLEGATION PROVED

<u>Allegation 2: You allowed a junior member of staff to convey your concerns and your decision in 1.2 to Patient A:</u>

51. The Committee considered the following evidence on this issue:

    a. Patient A provided evidence that she waited approximately 15 minutes before the trainee came round the counter and handed her back the prescription. The trainee was visibly distressed and said that Patient A could not have her medication. The trainee said, "*I can't dispense this for you because my manager isn't allowing me to give it to you*" or words to that effect.

    b. TS provided evidence that she knew that she had to speak to Patient A and inform them that they would need to return another day or visit another pharmacy. She had to speak to Patient A as the Registrant was too busy with other matters.

52. On a balance of probabilities, the Committee finds that the Registrant allowed a junior member of staff to convey his concerns and your decision in 1.2 to Patient A:

a. The Committee considered that the Registrant allowed TS to convey his decision concerning Patient A's prescription to Patient A, on the basis that she did convey his decision to Patient A.

b. The Committee considered that, although TS did not convey the Registrant's concerns to Patient A, the fact that she was permitted to convey the Registrant's decision, it would logically follow that TS would have been permitted to convey the Registrant's concerns to Patient A should she have asked her.

c. The Committee notes that Patient A speculated the reason for the Registrant allowing TS to convey his decision to Patient A is that the Registrant was "*cowardly*". However, TS does not speculate and provides evidence that the Registrant was too busy with other matters. Consequently, the Committee finds that the Registrant was too busy, rather than cowardly, to speak to Patient A. This is supported by the frank conversation that the Registrant had with Patient A 10 minutes later, which was recorded by Patient A.

ALLEGATION PROVED

<u>Allegation 3: Your conduct at paragraph 1 was discriminatory:</u>

53. The Committee noted the following from the Council's Good decision making: Fitness to practise hearings and outcomes guidance, Mach 2024:

a. "*Unlawful discrimination means treating a person unfairly because of their protected characteristics*". Gender reassignment is a protected characteristic under the Equality Act 2010.

b. "*Pharmacy professionals must treat their colleagues and patients fairly, whatever their life choices and beliefs. In line with our standards, we expect professionals to:*

i. *recognise their own values and beliefs but do not impose them on other people*

ii. *take responsibility for ensuring that person-centred care is not compromised because of personal values and beliefs.*"

c. Discrimination can include: "*treating a patient less favourably because of a protected characteristic.*"

54. On a balance of probabilities, the Committee finds the Registrant's conduct discriminatory on the basis that he treated Patient A less favourably than others. In particular:

a. TS provided evidence that the Registrant said there was no science behind it and asked her to provide evidence to support it, challenging her on the matter. In the context of the situation, TS considered the Registrant did not believe in transitioning. The Registrant's lack of belief in transitioning is supported by:

i. The recording of the contemporaneous conversation between Patient A and the Registrant set out that the Registrant said: "*I happen to be related to someone who has de-transitioned … He's now a proponent of saying I've changed for his, for no good reason, ok?*" The Registrant is using the case-study of his relative to support his lack of belief in transitioning.

ii. The Registrant did not raise his concerns with Patient A's Consultant, prescriber or GP. Raising concerns with a patient's Consultant, prescriber or GP where there is a concern over a prescription should be a known practice to an experienced pharmacist. The Registrant did not do this, indicating that he treated Patient A less favourably than others.

iii. Patient A provided evidence that the Registrant did not ask her any questions about her medical history or situation. There is no evidence before the Committee to counter this. Where there is a concern over a prescription, it would be best practice to ask the patient for further information; practice that should be a known to an experienced

pharmacist. The Registrant did not do this, indicating that he treated Patient A less favourably than others.

iv. The Registrant did not record his decision. Where there is a concern over a prescription, which is ultimately not issued, it would be best practice for a pharmacist to record this; practice that should be a known to an experienced pharmacist. The Registrant did not do this, indicating that he treated Patient A less favourably than others.

b. Patient A provided evidence that she felt discriminated against when requesting her medication from the Registrant.

ALLEGATION PROVED

Allegation 4: You communicated to Patient A, in a public place, by telling her the following contrary to NHS guidance:

4.1. that you do not agree with the Covid vaccine; and/or

4.2. would promote people not taking it.

55. The Committee considered the following evidence on this issue:

a. The recording of the contemporaneous conversation between Patient A and the Registrant set out that the Registrant said: "*And the same applies for COVID, (I'm or and) what happened to one of those people who have not received that vaccine, who promote people not doing it, because it's got scientific backing … But the, but people aren't listening to it.*"

b. Patient A provided evidence that the contemporaneous conversation between Patient A and the Registrant which she recorded, took place in the Pharmacy, which was a public setting, even though they had "stepped to the side" according to Patient A. This is confirmed by the video.

c. NHS Guidance promoting the use of the COVID-19 vaccine.

56. On a balance of probabilities, the Committee finds that the Registrant:

a. Told Patient A that there is scientific backing not to receive the COVID vaccine. In doing so, the Registrant communicated, in an implied manner, that he does not agree with the COVID vaccine. Furthermore, he told Patient A that "*But the, but people aren't listening to it.*" In doing so, the Registrant communicated, in an implied manner, that he would promote people not taking the COVID vaccine.

b. By undertaking the actions set out in paragraph 55(a), his actions were contrary to NHS advice.

c. The Registrant communicated the information set out in paragraph 55(a) in a public place.

ALLEGATION PROVED

Submissions on Grounds and Impairment

57. Having found particulars of allegation proved, the Committee went on to consider whether the allegations amounted to the grounds of misconduct and, if so, whether the Registrant's fitness to practise is currently impaired.

58. In relation to misconduct, on behalf of the Council, Mr Thomas submitted that the allegations amounted to misconduct. In particular:

a. The Registrant offered an insubstantial clinical reason or explanation that may have concealed a personal belief. In his refusal to dispense Patient A's medication, the Registrant badly mishandled the situation with the effective result being the imposition of his belief on Patient A without following applicable guidance issued by the Council. This risked interrupting Patient A's therapy when she attended the Pharmacy with a reasonable expectation that the medication would be dispensed as it had in the past.

b. Although the Registrant was polite, he did not fully treat Patient A with empathy and compassion. The patient was upset. The effect of the Registrant's actions was discriminatory on the basis of a protected characteristic.

c. The Registrant failed to raise whatever clinical concerns he had with fellow practitioners; did not record his decision; and did not initially speak to the patient directly.

d. The Registrant's reliance on a junior colleague was in the circumstances inappropriate and distressing and showed poor leadership. It was not good enough for the Registrant to be too busy.

e. It is unclear why the Registrant thought that he was competent to take a unilateral decision on supply when the hormones had been prescribed under the guidance of a specialist.

f. The Registrant's conduct, as set out in the proven allegations, constituted a breach of the following Standards:

    i. Standard 1: Pharmacy Professionals must provide person-centred care.

    ii. Standard 2: Pharmacy Professionals must work in partnership with others.

    iii. Standard 3: Pharmacy Professionals must communicate effectively.

    iv. Standard 4: Pharmacy Professionals must maintain, develop and use their professional knowledge and skills.

    v. Standard 5: Pharmacy Professionals must use professional judgement.

    vi. Standard 6: Pharmacy professionals must behave in a professional manner.

    vii. Standard 9: Pharmacy professionals must demonstrate leadership.

g. In relation to Allegation 4, the Registrant's comments about the COVID vaccine could have had the effect of discouraging members of the public from accessing treatment and services that are advised for their benefit and wider society, again based on the Registrant's personal beliefs. However, the Committee should consider the facts carefully before concluding that this conduct amounts to serious professional misconduct in its own right. The Council acknowledges that the Registrant's comments to Patient A were not spoken with the apparent intention of trying to persuade her not to have the Covid vaccine. If anything, he

appears to have assumed that she would not listen to him. The remarks appear to have been made in the course of further illustrating the type of personal or clinical judgements that the Registrant makes and stands by even if that means being an outlier among health practitioners. In all the circumstances, there was little prospect of Patient A or anyone else being swayed by the comments.

59. The Registrant was not present or represented to make submissions on misconduct, other than those contained in the bundle.

60. In relation to current impairment, on behalf of the Council, Mr Thomas submitted that:

a. It is accepted that there is no evidence that the Registrant acted with malice towards Patient A. However, he mishandled a fundamental issue with the effect that a patient was left without her medication.

b. The Registrant's actions presented a potential risk to Patient A that she would not promptly receive her usual medication that was subject to clinical oversight.

c. Discriminatory conduct, or presenting what was really a personal belief as a clinical judgement, has the potential to bring the profession into disrepute (especially in this case among trans people, who might be deterred from using community pharmacies).

d. Not providing person-centred care and putting his own interests above those of Patient A amounts to a breach of a fundamental principle of the profession.

e. Whether the Registrant's misconduct amounts to a lack of integrity is a matter for the Committee. A lack of integrity could be established if it is found that the Registrant placed his beliefs and interests above those of Patient A. Such action would not adhere to the ethical standards of the pharmacy profession. There is no allegation of dishonesty.

f. There is little by way of insight. The Registrant has not accepted that he was wrong to refuse to dispense the medication, although he concedes that it was remiss of him not to record the incident. The Registrant's explanation has been defensive but not substantial. He has shown no empathy for the predicament of

Patient A and provided no reflection on how his conduct could undermine confidence in the profession or what he might have done differently.

g. There has been no remorse, apology or reflection by the Registrant of the impact of his actions upon patients, colleagues or the profession.

h. By not attending the hearing and not providing written submissions or reflections, he has not taken an opportunity to demonstrate insight and learning. There is no acknowledgment that the standards may have been breached and in all the circumstances there is a risk of repetition. It is unclear whether any underlying attitudinal issues have been addressed.

i. There remains a wider need to declare and uphold professional standards and to maintain public confidence in pharmacists.

61. The Registrant was not present or represented to make submissions on current impairment, other than those contained in the bundle.

Decision on Grounds

62. The Committee took account of the guidance given to the meaning of "*fitness to practise*" in the Council's publication *"Good decision-making"* (Revised March 2024).

63. The Committee accepted and applied the following definition of "*misconduct*":

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

64. The Committee also took into account the observation of J Collins in *Nandi v GMC [2004] EWHC 2317 (Admin)* that: "*The adjective 'serious' must be given its proper*

weight and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners."

65. The Committee considered that by committing the conduct set out in the proven parts of allegations 1 and 3, the Registrant fell short of what would be proper in the circumstances, and would be regarded as deplorable by fellow practitioners. The Registrant failed to provide patient centred care, and acted in a discriminatory manner, by refusing to dispense to Patient A their prescribed medication:

    a. When it was clinically indicated;

    b. without making enquiries or consulting with Patient A, Patient A's prescriber and/or General Practitioner; and

    c. without recording his decision.

66. The Committee does not consider that the Registrant's proven conduct in allegations 2 and 4 amount to misconduct, given:

    a. In relation to allegation 2, He allowed a junior member of staff to convey his dispensing decision to Patient A as he was too busy. When he was asked by Patient A to provide his reasoning, he did so.

    b. In relation to allegation 4, the Registrant's comments about the COVID vaccine were not spoken with the intention of trying to persuade Patient A not to have the COVID vaccine. If anything, the Registrant appears to have assumed that she would not listen to him. The remarks appear to have been made in the course of further illustrating the type of personal or clinical judgements that the Registrant makes and stands by even if that means being an outlier among health practitioners. In the circumstances, there was little prospect of Patient A or anyone else (if the conversation was heard in full by another) being swayed by the comments.

67. The Registrant's misconduct in the proven parts of allegations 1 and 3 damage public confidence in the profession, as it would convey a degree of opprobrium to the ordinary intelligent citizen (*Shaw v General Osteopathic Council [2015] EWHC 2721 (Admin)*).

68. The Committee considered whether the Registrant had breached any of the Council's Standards. The Committee determined that there had been a breach of the following Standards as a result of the misconduct:

a. Standard 1: Pharmacy Professionals must provide person-centred care. In particular:

i. involve, support and enable every person when making decisions about their health, care and wellbeing and listen to the person and understand their needs and what matters to them. The Registrant did not make enquires with Patient A about her, her health or her circumstances before refusing to dispense her prescription.

ii. recognise and value diversity, and respect cultural differences – making sure that every person is treated fairly whatever their values and beliefs. The Registrant did not raise his concerns with Patient A's Consultant, prescriber or GP. Raising concerns with a patient's Consultant, prescriber or GP where there is a concern over a prescription should be a known practice to an experienced pharmacist. The Registrant did not make enquires with Patient A about her, her health or her circumstances before refusing to dispense her prescription. Where there is a concern over a prescription, it would be best practice to ask the patient for further information; practice that should be a known to an experienced pharmacist. The Registrant did not record his decision. Where there is a concern over a prescription, which is ultimately not issued, it would be best practice for a pharmacist to record this; practice that should be a known to an experienced pharmacist. The Registrant did not do these things, indicating that he treated Patient A less fairly than others.

iii. recognise their own values and beliefs but do not impose them on other people, and take responsibility for ensuring that person-centred care is not compromised because of personal values and beliefs. The recording of the contemporaneous conversation between Patient A and the Registrant set out that the Registrant said: "*I happen to be related to someone who*

has de-transitioned … He's now a proponent of saying I've changed for his, for no good reason, ok?" The Registrant is using the case-study of his relative to impose his own values on Patient A.

b. Standard 2: Pharmacy Professionals must work in partnership with others. In particular:

   i. work with the person receiving care. The Registrant did not make enquires with Patient A about her, her health or her circumstances before refusing to dispense her prescription.

   ii. identify and work with the individuals and teams who are involved in the person's care. The Registrant did not raise his concerns over Patient A's medication with Patient A's Consultant, prescriber or GP.

   iii. make and use records of the care provided. The Registrant did not record his decision.

c. Standard 3: Pharmacy professionals must communicate effectively. In particular:

   i. ask questions and listen carefully to the responses, to understand the person's needs and come to a shared decision about the care they provide. The Registrant did not make enquires with Patient A about her, her health or her circumstances before refusing to dispense her prescription.

   ii. communicate effectively with others involved in the care of the person. The Registrant did not raise his concerns over Patient A's medication with Patient A's Consultant, prescriber or GP.

d. Standard 4: Pharmacy professionals must maintain, develop and use their professional knowledge and skills. In particular recognise and work within the limits of their knowledge and skills, and refer to others when needed. The Registrant did not raise his concerns over Patient A's medication with Patient A's Consultant, prescriber or GP. The Registrant provided evidence that he "*did not contact the prescribing GP on this occasion. In the past, I have raised similar concerns regarding prescriptions of this nature with the GP and nurse on four*

separate occasions. Each time, I received different responses, none of which provided new information or altered my clinical judgment or subsequent actions." Each patient must be treated on their own merits. Where a pharmacist is concerned about a prescription, they should, on all occasions, raise concerns with the GP or prescriber as this patient could have a specific reason for being prescribed a particular medicine.

e. Standard 5: Pharmacy professionals must use their professional judgement. In particular, have the information they need to provide appropriate care. The Registrant did not raise his concerns over Patient A's medication with Patient A's Consultant, prescriber or GP. The Registrant did not make enquires with Patient A about her, her health or her circumstances before refusing to dispense her prescription.

f. Standard 6: Pharmacy professionals must behave in a professional manner. In particular:

g. act with integrity. See paragraph 82-83 below.

69. The Committee bore in mind that the Standards may be taken into account when considering the issues of grounds and impairment but that a breach of the Standards does not automatically establish that the Registrant's fitness to practise is impaired (Rule 24(11)).

70. Accordingly, the Committee concluded that, in its judgement, the grounds of misconduct are established.

Decision on Impairment

71. Having found that the particulars of allegation amounted to misconduct, the Committee went on to consider whether the Registrant's fitness to practise is currently impaired.

72. At the outset, the Committee considered the Registrant's insight and remediation.

73. The Committee considered that the Registrant has demonstrated little insight. Although the Registrant has said that it was remiss of him not to record the incident, the Committee has not found evidence of any other insight. In particular:

a. The Registrant has not accepted that he was wrong to refuse to dispense the medication.

b. The Registrant has not apologised to Patient A.

c. The Registrant has not provided reflection on:

i. how his conduct could impact upon patients and colleagues;

ii. how his conduct could undermine confidence in the profession;

iii. what he might have done differently;

iv. the gravity of the misconduct; or

v. the Standards which may have been breached.

74. The Committee considered that the Registrant's proven misconduct can be remediated, but the Registrant has not completed any remediation:

a. The Registrant has not denied any failings in his actions.

b. There is no evidence before the Committee that the Registrant has put in place steps to prevent similar misconduct in the future.

c. There is no evidence before the Committee to determine whether any underlying attitudinal issues have been addressed.

75. The Committee considered whether the particulars found proved show that actions of the Registrant:

a. present an actual or potential risk to patients or to the public;

b. have brought, or might bring, the profession of pharmacy into disrepute;

c. have breached one of the fundamental principles of the profession of pharmacy; or

d. mean that the integrity of the Registrant can no longer be relied upon.

Whether the Registrant's conduct or behaviour presents an actual or potential risk to patients or to the public

76. The Committee considered that the Registrant's misconduct and behaviour, as set out in paragraph 65 above, presented an actual risk of harm to patients. In particular, the Registrant's misconduct – in failing to go through due process – raised the risk that Patient A would not access her medication. CS provided evidence that Patient A not taking oestrogen, in the long-term, would lead to osteoporosis, cognitive issues and muscle waste.

77. Given the limited insight and lack of remediation completed by the Registrant, as set out in paragraphs 73-74 above, the Committee considers that the Registrant's conduct or behaviour is likely to be repeated. Consequently, the Registrant presents an actual or potential risk to patients or to the public in the future.

Whether the Registrant's conduct or behaviour has brought, or might bring, the profession of Pharmacy into disrepute

78. The Committee considered that the Registrant's misconduct, as set out in paragraph 65 above, has brought the profession of pharmacy into disrepute.

79. Given the limited insight and lack of remediation completed by the Registrant, as set out in paragraphs 73-74 above, the Committee considers that the Registrant's conduct or behaviour might bring the profession of pharmacy into disrepute in the future.

Whether the Registrant's conduct or behaviour has breached one of the fundamental principles of the profession of Pharmacy

80. The Committee considered that the Registrant's misconduct, as set out in paragraph 65 above, has breached more than one of the fundamental principles of the profession of pharmacy, namely the failure to:

a. Provide person-centred care;

b. Work in partnership with others;

c. Communicate effectively;

d. Maintain, develop and use their professional knowledge and skills;

e. Use professional judgement; and

f. Behave in a professional manner.

81. Given the limited insight and lack of remediation completed by the Registrant, as set out in paragraphs 73-74 above, the Committee considers that the Registrant's conduct or behaviour is likely to breach one of the fundamental principles of the pharmacy profession in the future.

Whether the Registrant's conduct or behaviour shows that the integrity of the Registrant can no longer be relied upon

82. The case of *Wingate v Solicitors Regulation Authority [2018] EWCA Civ 366* sets out:

> "*Integrity connotes adherence to the ethical standards of one's own profession. That involves more than mere honesty. To take one example, a solicitor conducing negotiations or a barrister making submissions to a judge or arbitrator will take particular care not to mislead. Such a professional person is expected to be even more scrupulous about accuracy than a member of the general public in daily discourse*."

83. Further to the case of *Wingate*, and through his conduct as set out in paragraph 65 above, the Committee considered that the Registrant's actions demonstrate a lack of integrity. The Committee has considered that the Registrant's actions at the proven parts of allegation 1 amount to discriminatory behaviour. The Registrant's proven actions in allegation 1 had the effect of placing the Registrant's views over those of Patient A. The Registrant held power when doing so, as he could withhold the dispensing of Patient A's medication by placing his views over the needs of Patient A. This, in the view of the Committee, is the Registrant not adhering to the ethical standards of the pharmacy profession.

84. Given the limited insight and lack of remediation completed by the Registrant, as set out in paragraphs 73-74 above, the Committee considers that the Registrant's

conduct or behaviour is likely to show that the integrity of the Registrant can no longer be relied upon.

Impairment in the wider public interest

85. Members of the public would be concerned to learn that a pharmacist had conducted the actions set out in the proven allegations. The effect of the misconduct was discriminatory and denied Patient A access to her prescribed medication.

86. Consequently, the Committee considered the Registrant's fitness to practise to be impaired on the wider public interest element, namely maintaining public confidence in the pharmacy profession and upholding professional standards.

Committee's conclusion on impairment

87. In light of the above, the Committee considered the Registrant's fitness to practise to be currently impaired to protect the public and in the wider public interest.

Outcome

88. Having found current impairment, the Committee has gone on to consider the matter of outcome. The Committee's powers are set out in Article 54(2) of the Pharmacy Order 2010. The Committee should consider the available outcomes in ascending order from least restrictive, take no action, to most restrictive, removal from the register, in order to identify the appropriate and proportionate outcome that meets the circumstances of the case.

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

90. The Committee had regard to the Council's "*Good decision making: Fitness to practise hearings and outcomes guidance*", published in March 2024 ("Guidance"), to inform its decision.

91. On behalf of the Council, Mr Thomas submitted:

a. Aggravating factors include:

i. Although this was a single incident, it is serious because it breached a large number of the professional standards and could present obstacles to patients (in this case trans people) accessing care or receiving services.

ii. The misconduct was found to amount to a lack of integrity.

iii. The Registrant's misconduct had an adverse impact upon Patient A, potentially disrupting her continuity of care.

iv. The Registrant did not make any enquiries of Patient A or listen to her.

v. The Registrant was in a position of power, authority and trust, imposing his beliefs on a patient in a way which is discriminatory.

vi. The Registrant did not properly express his clinical reason to Patient A.

vii. By referring to the transitioning experiences of a family member when considering the dispensing of Patient A's medication, the Registrant was not providing patient-centred care to Patient A.

viii. The Registrant's actions caused distress to TS.

b. Mitigating factors include:

i. In mitigation it might be noted that the Registrant did not obstruct Patient A from obtaining her medication from another source and made some suggestions for how to do this (without going so far as to make the arrangements himself).

ii. It is possible that the Registrant was attempting to reconcile a genuinely held personal belief to professional responsibilities and badly misjudged

the situation, rather than acting out of malice. However, it is a matter for the Committee to determine whether this is a mitigating factor.

iii. The Registrant provided some *de facto* admissions in his written submissions.

iv. The Registrant has no previous fitness to practise concerns.

c. Taking no further action or issuing a warning would be insufficient to mark the seriousness of the misconduct, especially in light of a finding of discrimination. The public would not be reassured by taking no further action or issuing a warning, as:

i. there remains a risk of harm, indicating attitudinal factors;

ii. the Registrant's integrity can no longer be relied upon; and

iii. there has been no remediation from the Registrant.

d. Conditions would not be appropriate or workable to address the concerns posed by the Registrant, which are attitudinal in nature. Although conditions could be imposed requiring decisions to be captured or to consult with a colleague, but this would not capture the essences of the misconduct. Furthermore, there is no guarantee that the Registrant would adhere to conditions, given his lack of engagement with this fitness to practise proceedings. Conditions would also not meet the wider public interest of maintaining public confidence in the profession and declaring and upholding proper standards of conduct and behaviour.

e. The absence of an apology, reflection and learning, or engagement in the regulatory process, is concerning and suggests that a more severe outcome may be required. The Council's position is that only suspension of 6-9 months would adequately protect patients and the public, ensure that standards are upheld, and maintain trust and confidence in the profession. The need for a suspension is strengthened by the Committee's finding that the Registrant's integrity can no longer be relied upon.

f. This misconduct can be remediated; therefore, a removal order would be premature at this stage.

92. The Registrant was not present or represented to make submissions on outcome, other than those contained in the bundle.

93. The Committee considered the following to be mitigating factors in this case:

a. The Registrant did not obstruct Patient A from obtaining her medication from another source and made some suggestions for how to do this.

b. The Registrant provided some *de facto* admissions in his written submissions.

c. The Registrant has no previous fitness to practise concerns.

d. The Registrant has worked unrestricted and without an incident being brought to the attention of the Committee since the time of the allegations.

94. The Committee considered the following to be aggravating factors in this case:

a. Although this was a single incident, it is serious because it breached a large number of the professional standards and could present obstacles to patients (in this case trans people) accessing care or receiving services.

b. The misconduct was found to amount to a lack of integrity.

c. The Registrant's misconduct had an adverse impact upon Patient A, potentially disrupting her continuity of care.

d. The Registrant did not make any enquiries of Patient A or listen to her.

e. The Registrant was in a position of power, authority and trust, imposing his beliefs on a patient in a way which is discriminatory.

95. The Committee considered that the Registrant's proven misconduct makes taking no action or imposing a warning insufficient to adequately protect the public (given the Registrant's limited insight and lack of remediation), and to meet the wider public interest of maintaining public confidence in the profession and declaring and upholding proper standards of conduct and behaviour. This is especially in light of:

a. The finding of discrimination;

b. there remains a risk of harm; and

c. the Registrant's integrity can no longer be relied upon.

Therefore, the Committee finds that taking no action or issuing a warning to be inappropriate.

96. The Committee next considered the imposition of conditions of registration on the Registrant. The Committee considered that conditions could not be formed, or would not be workable, to address the risk to the public posed by the Registrant, given:

a. the aggravating and mitigating factors;

b. that the Registrant's integrity can no longer be relied upon;

c. the misconduct was not to do with the Registrant's clinical competence;

d. conditions would not capture the essence of the misconduct; and

e. there is no guarantee that the Registrant would adhere to conditions, given his lack of engagement with this fitness to practise proceedings.

Furthermore, conditions would not be appropriate to mark the seriousness of the proven misconduct. The Committee considered that conditions would not adequately meet the wider public interest of maintaining public confidence in the profession and declaring and upholding proper standards of conduct and behaviour.

97. The Committee next considered whether suspension would be an appropriate and proportionate outcome. The Committee considered that a suspension would be an appropriate and proportionate outcome, given:

a. A warning or conditions have been found not to be sufficient to deal with any risk to patient safety or to protect the public, and would undermine public confidence.

b. The Registrant's lack of engagement in the fitness to practise proceedings.

c. That the Registrant's integrity can no longer be relied upon.

d. The Registrant has demonstrated limited insight, but this needs to be further developed, along with sufficient remediation.

e. The Registrant has practiced without any known concern since the allegations.

f. The misconduct can be remediated and the Registrant should be given an opportunity to remediate it.

98. Consequently, the Committee considered a suspension of 6 months to be appropriate and proportionate. This would:

a. Mark the seriousness of the misconduct; and

b. Provide sufficient time for the Registrant to complete sufficient remediation and develop sufficient insight.

99. For the reasons set out in paragraph 97, the Committee considered that removal from the register was a disproportionate and inappropriate outcome.

Review Hearing

100. The Committee directs that a review takes place prior to the end of the six-month suspension. Any reviewing committee would be assisted by:

a. An apology from the Registrant to Patient A concerning the misconduct.

b. A reflective piece from the Registrant setting out:

i. His consideration whether he was wrong to refuse to dispense Patient A's medication;

ii. how the proven misconduct could impact upon patients and colleagues;

iii. how the proven misconduct could undermine confidence in the profession;

iv. what he might have done differently;

v. the gravity of the misconduct; and

vi. the Standards which may have been breached.

c. A demonstration of the understanding of the Equality Act 2010. This can be demonstrated by training in the area of discrimination.

d. Consideration from the Registrant of steps that he has put in place to prevent similar misconduct in the future.

e. The Registrant's attendance at any review hearing.

Decision on Interim Measures

101. On behalf of the Council, Mr Thomas made an application for an interim measure of suspension to be imposed on the Registrant's registration, to take effect from today's date, pursuant to Article 60 of the Pharmacy Order 2010, pending the coming into force of the Committee's substantive order. He submitted that:

a. The Committee has found the Registrant to be currently impaired on the wider public interest and for public protection. There is an ongoing risk given that the Registrant's conduct has not been sufficiently remediated. Furthermore, there is a finding that the Registrant's integrity can no longer be relied upon. It is for public protection and in the wider public interest that interim measures are put in place.

b. Even though the Registrant has not been previously subject to an interim order, matters have now moved on in that the Registrant has had the allegations against him proved at a Principal Hearing. Not implementing interim measures would be contrary to the Committee's findings.

c. An immediate suspension may impact upon the Registrant as he has mentioned that he is "*at work*" during this hearing and that he wanted to be recompensed for any time he attended the hearing. Further, the Registrant has worked without incident since the time of the allegations.

102. The Registrant was not present or represented to make submissions on interim measures.

103. In considering Mr Thomas' application, the Committee took account of the fact that its decision to suspend the Registrant from the Council register will not take effect until 28 days after the Registrant is formally notified of the outcome, or until any appeal is concluded.

104. The Committee considered that an interim measure was necessary given:

a. It has found that there remains a risk that the Registrant might repeat his conduct, as set out in the proven allegations, if permitted to return to work unrestricted. This risk was not previously assessed prior to the Principal Hearing.

b. The Registrant's misconduct would have had an impact on public confidence. The Committee was satisfied that it was necessary for an interim measure to be put in place to safeguard the public interest during the appeal period.

105. The Committee is satisfied that it is therefore appropriate for an interim measure to be in place prior to the taking effect of the substantive order.

106. 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.

107. This concludes the determination.