

Reforming our fitness to practise investigation and adjudication processes

Equality analysis

Scope

- 1 We follow rules when investigating and acting on concerns about doctors. This equality analysis assesses how proposed changes to those rules comply with the equality duty.
- 2 Between 25 March and 20 May, we ran a public consultation on our proposals for change (<http://www.gmc-uk.org/concerns/26390.asp>). Our consultation document provided an overview of the main changes that we propose making to our rules. These include amending:
 - a rules to reflect changes to *the Medical Act 1983* – the Department of Health (England) analysed the equality implications of these changes and we have not included these in this analysis
 - b existing rules or adding new rules to implement the changes to the *Medical Act 1983* – these are included in the scope of this analysis
 - c existing rules that improve our processes (not related to the *Medical Act 1983* changes) – these changes are also included in this analysis.

Background

- 3 The Medical Practitioners Tribunal Service (MPTS) runs the hearings at which decisions are made about a doctor's fitness to practise. We set up the MPTS in shadow form in June 2012 to make sure that investigations of complaints about doctors are operationally separate from running and making decisions at these hearings.
- 4 To achieve this, and to further streamline our processes, we are changing the *Medical Act 1983* and our rules. The Department of Health (England) has taken forward changes to the *Medical Act 1983*, which include:

- a** establishing the MPTS in law, so that any future fundamental changes to the MPTS will have to be approved by Parliament
 - b** revising our statutory objective to an overarching objective of protecting the public with three supporting limbs, to protect the health and well-being of the public, maintain confidence in the profession and maintain the standards of the profession
 - c** introducing a new right of appeal for the GMC on grounds that a decision of the MPTS is not sufficient to meet the revised statutory objective
 - d** modernising the MPTS adjudication function, including strengthening case management arrangements and providing flexibility around when to appoint a legally qualified chair or a legal assessor (and in some cases, both)
 - e** giving panels the powers to deal with a situation where the doctor or the GMC has delayed a hearing, including awarding costs against either party where they have not complied with a direction or rule and have behaved unreasonably
 - f** introducing a new power to require disclosure of information from a doctor and allowing a new type of hearing where a doctor fails to comply with that request or fails to engage with an assessment
 - g** when sanctions are being reviewed and both the GMC and doctor agree on the proposed outcome of the review, allowing a panel or panel chair to consider all the information provided by both parties in writing, and to make a decision without the parties having to attend a hearing
 - h** making the way we conduct assessments more flexible.
- 5** The Department of Health conducted a public consultation on these changes. The Section 60 Order amending the *Medical Act 1983* was approved by the Privy Council on 19 March 2015.

Our proposals for change

- 6** To complete the reform programme, we must also make changes to our rules. We consulted on these proposals which included:
- a** creating the governance structure needed for the MPTS Committee
 - b** where legally qualified chairs give advice to the panel on a question of law (and a legal assessor is not present), providing that they give advice in the presence of the parties or, where the parties are not present, in their decision

- c** allowing the MPTS to set and publish the criteria for appointing panellists and panel chairs
- d** making it clear who is responsible for telling doctors about allegations and hearings
- e** establishing the circumstances in which case managers' decisions will not be binding
- f** providing a process for awarding costs and assessing how much a party has to pay
- g** establishing the process for the new type of non-compliance hearing
- h** removing the need to tell a doctor's employer about provisional enquiries until we have decided there is a concern that requires investigation.

7 As a result of these changes, we expect to:

- a** increase patients', public and doctors' confidence that doctor's hearings are impartial by formally separating our investigation and adjudication roles
- b** streamline and modernise our hearing process, and reduce unnecessary delays, by making the process simpler and more effective
- c** make case management more effective and improve compliance by both parties with case managers' decisions
- d** save time and money for both parties by removing the need for parties to attend review hearings in person where the proposed outcome is agreed
- e** make our investigation process simpler and more effective
- f** improve compliance with an investigation and the assessment we carry out during an investigation.

8 We aim to implement the majority of these changes by 31 December 2015. The revised statutory objective (referred to above) and the duty to have regard to this revised objective came into force on 3 August 2015 (in line with similar changes to the objectives of other healthcare regulators).

9 We have started an implementation programme and will review and update this analysis as the programme progresses.

Action: To update this analysis in line with developments as the changes are implemented.

Consultation and engagement

- 10 The public consultation on our proposals for change closed on 20 May 2015. In order to understand the views of people with protected characteristics and any disproportionality or fairness issues arising from these changes, we:
 - a included a question about whether any of the proposed changes will adversely affect people from any of our interest groups who share protected characteristics
 - b encouraged respondents to provide us with their diversity data, in order to see whether there are any trends in responses for people with particular protected characteristics.
- 11 In a previous version of this analysis we identified an action to analyse and report on any trends for people with protected characteristics who respond to the consultation, and to update this equality analysis accordingly. Our update is set out below.

Who will be affected by our proposals?

- 12 The changes to our rules will affect anyone involved in our fitness to practise procedures, in particular doctors, their legal representatives, witnesses and complainants.
- 13 We expect that some of the changes could have a disproportionate impact on doctors without legal representation ('unrepresented doctors') who will share a number of protected characteristics defined by equality legislation.

Evidence

Doctors

- 14 We collect data on the age, sex and race of a doctor. We do not currently collect data on the other protected characteristics for doctors on the register. Our Strategy and Policy Board has agreed to move towards collecting data on disability, sexual orientation and religion or belief on registrants in future.
- 15 We publish information annually about trends for doctors (including those who share the protected characteristics of age, race and sex) who are involved in our fitness to practise procedures. The analysis of our data* indicates some overall trends for doctors with particular protected characteristics:

* *The State of Medical Education and Practice in the UK report, 2014*, GMC at http://www.gmc-uk.org/Chapter_2_25112014.pdf 58752936.pdf

- a** male doctors and older doctors are more likely than female doctors or younger doctors to receive a complaint and have that complaint investigated
 - b** non-UK graduates are more likely than UK graduates to receive a complaint and to have that complaint investigated
 - c** age, gender, place of primary medical qualification and ethnicity affect the likelihood of receiving a sanction, with older, male doctors who are EEA qualified or International Medical Graduates (IMG) more likely to receive a sanction and BME doctors more likely than white doctors to receive a sanction.
- 16** Although we do not know exactly why these groups are at greater risk of complaints and sanctions, the different types of allegations that arise for these groups and the source of referral impact significantly on doctors having a higher chance of receiving a sanction or warning. Allegations involving criminality or health have a higher probability of resulting in a sanction or warning, as do referrals received from employers. In general a higher proportion of cases about non-UK graduates and BME doctors involve allegations about criminality/health and a higher proportion of complaints about them are from employers.

Unrepresented doctors

- 17** We anticipate that the reforms to our rules could have a disproportionate impact on unrepresented doctors, who will share a number of protected characteristics. We have limited data on the profile of these doctors (in terms of gender, age, place of primary qualification and ethnic background).
- 18** We know from our analysis of this data over the period from 2007 to 2014 that 907 doctors were not represented at a total of 915 hearings (both Fitness to Practise and Interim Orders Panels). Unrepresented doctors are more likely to be male (85%), IMG (47% compared to 37% UK graduates) and between the ages of 40 and 59 (52%).
- 19** The data we have in relation to ethnic origin is inconclusive, as the ethnicity of 38% of the unrepresented doctors who were involved in our procedures during this period is not known.

Perceptions and confidence

- 20** In May 2014 we published independent research* to help us to understand:

* 'Fairness and the GMC', NatCen Social Research, May 2014

- a** whether we are perceived to be fair by doctors
 - b** confidence in our approach to regulating doctors, and the extent to which doctors trust us to discharge our core activities
 - c** whether doctors' views about the GMC vary by ethnicity or where they qualified.
- 21** Most doctors (86%) thought that the GMC investigates concerns fairly for the majority of doctors. 83% of White doctors and 78% of BME doctors thought they would be treated fairly in an investigation.
- 22** More than one in four doctors thought that our fitness to practise (FTP) procedures were more fair now than they were five years ago. This view was more common among BME doctors (31%) than white doctors (26%). In fact the group most likely to say that proceedings are more fair now were non-UK qualified BME doctors – more than one in three said this (35%).
- 23** The majority of doctors (81%) thought that they would be treated fairly if a concern was raised about them. This was the case for both white and BME doctors. Among white doctors the most common reason given for thinking that they might be treated unfairly was that the process was in some way biased. For BME doctors the most common reason given was their ethnicity.

Consultation outcome

- 24** 84 individual respondents provided us with equality data. A breakdown of this data is included at Annex B. We also analysed responses on a question by question basis to identify trends. No trends were identified.
- 25** We asked respondents whether they thought our proposals would adversely impact on people from groups with protected characteristics. 48 respondents (57% of those who responded to the question) said there would be no adverse impact. 13 (15%) thought there would be an adverse impact.
- 26** Five respondents highlighted the overrepresentation of BME doctors and non-UK qualified doctors in our processes. One respondent said that older males were also overrepresented.
- 27** The BMA raised concerns about the impact of proposals to refer doctors with undertakings to a panel where their English language had deteriorated as adversely affecting BME doctors for whom English was their second language.
- 28** One doctor was concerned about the impact on doctors with health problems and pregnant female doctors.

- 29** The Royal College of Physicians said the process was legalistic and may disadvantage doctors with health concerns and unrepresented doctors.
- 30** Respondents also made comments in relation to the specific proposals and we have reflected these in our equality analysis at Annex A.

Equality analysis

- 31** We have considered the impact of making changes to our rules on people with protected characteristics, the consultation outcome and the aims of the equality duty, throughout the development of our proposals. These are explored in more detail in the table at Annex A.
- 32** We believe that our proposals for changes to our rules are compliant with the aims of the equality duty. The main equality and diversity considerations related to the proposed changes are:
- a** ensuring that the MPTS and GMC fitness to practise procedures remain fair and robust
 - b** ensuring our selection and recruitment procedures for members of the MPTS statutory committee and panellists is fair and transparent
 - c** ensuring that we continue to monitor the impact of the changes on people with protected characteristics
 - d** assessing whether the reforms will disadvantage or create barriers for people who share protected characteristics.
- 33** Taking into account the outcome of our consultation, we think that a number of the proposals have the potential to benefit persons involved in our fitness to practise processes who share a protected characteristic. For example these include:
- a** Establishing the MPTS in statute which may provide additional assurance of the impartiality of panels and panel decisions through formal separation from the GMC's investigative function.
 - b** Providing for transparent governance of the MPTS statutory committee.
 - c** The fairness of our proceedings which will be supported by provisions allowing legally qualified chairs to repeat legal advice they give to the panel on a question of law.
 - d** Provisions to streamline the procedure at hearings will support the transparency of our hearing process benefitting those involved, including unrepresented doctors.

- e Providing flexibility to panellists to decide that a case management decision is not binding will support fairness for doctors, in particular unrepresented doctors.
- f Providing powers to case managers and Investigation Committee members to adjourn part heard hearings where the parties agree will reduce the number of panel hearings and save time benefitting all those involved in our hearings.

34 To the extent that the proposals impose burdens, we will put measures in place to avoid less favourable treatment on account of protected characteristics. For example:

- The introduction of costs could impact on an individual doctor. We are developing the detail of the model with a view to ensuring that it is fair for example ensuring that a doctor's ability to pay is taken into account in determining the level of costs.
- Non-compliance hearings could impact on an individual doctor who had failed to comply with an investigation. There will be safeguards in the process that ensure that doctors get a number of reminders about the need to comply and the consequences before non-compliance proceedings are progressed and any non-compliance order will be able to be removed when a doctor complies.

Action: To put in place measures to avoid less favourable treatment on account of a protected characteristic.

Reviewing and monitoring

- 35** We have updated this equality analysis to reflect: the responses to our public consultation; and our response and recommendations approved by Council in September 2015.
- 36** Progress against the actions identified will be reviewed periodically at the Section 60 implementation programme board meetings.
- 37** The 15 workstream project teams will also consider the equality and diversity implications and the aims of the equality duty as they develop the detailed plans for implementing the changes.

Actions:

To review the actions from this equality analysis at the Section 60 Implementation Project Board.

To consider equality and diversity and the aims of the equality duty in developing the plans to implement the changes.

Annex A

Equality Analysis

Changes to the rules	E&D considerations	Consultation outcome relating to fairness in our process or impact on people with protected characteristics, with recommendations made approved by Council.	Impact Positive/Neutra l/ Negative	Mitigation/Justification	Complies with the equality duty?
Section 1: Formally separating our investigation and adjudication functions					
Providing new rules for the MPTS committee	The rules provide for clear governance of the MPTS statutory committee including provision for appointing and removing members. Clear, robust procedures will enhance public confidence in the service and the operational separation from our investigation function	One respondent said our proposed changes would not address concerns about unconscious bias in MPTS decision making. Decisions makers will be trained on unconscious bias and their role in making sure that procedures are fair.	Neutral	N/A	Yes - as positions become vacant, we will provide a robust and transparent process to appoint a Chair and members compliant with the equality duty.

Transfer of responsibility for appointing and maintaining lists of panellists to the MPTS	This change will enhance the operational separation of our investigation and adjudication functions.	<p>One respondent asked whether the criteria for appointments will be made public.</p> <p>Panel members and chairs are appointed against a set of competence-based criteria. We will publish these criteria.</p>	Neutral	N/A	Yes. We will encourage the MPTS to continue to recruit panellists using a robust recruitment process and to provide E&D training.
Providing in rules for legally qualified chairs, where a legal assessor is not present, to advise the panel on a point of law in the presence of the parties or, where the parties are not present, in their decision	This will make sure that hearings where a legal assessor is not present, continue to be conducted in a fair and transparent manner for all parties and, in particular, unrepresented doctors.	<p>Respondents raised concerns about legally qualified chairs giving advice in private.</p> <p>We have amended the Rules to include, where advice is given after a panel has begun to deliberate, a discretion for the panel to return to open session where the legally qualified chair can give advice in the presence of the parties and invite submissions from them.</p> <p>One respondent commented that legally qualified chairs may be more pointed in how they express themselves and this may adversely impact on</p>	Positive	N/A	Yes

		doctors with health problems. We will continue to provide equality and training for MPTS panellists.			
Separating out the notice of allegation (the GMC to send) and the notice of hearing (the MPTS to send)	This change will enhance the operational separation of our investigation and adjudication functions.	Four respondents commented that duplication of correspondence would cause stress for doctors. We have developed the relevant process to include a review of the impact on the doctor before sending the notices. We will also consider this as part of our review of health cases following the independent review of suicides of doctors in our processes.	Neutral	N/A	Yes
Giving doctors at least 28 days' notice of all matters relating to a hearing (reflecting current practice)	This change reflects our current practice which provides parties (including unrepresented doctors) adequate notice of all details		Neutral	N/A	Yes

	relating to the hearing.				
Removing the need for the MPTS to refer cases to the GMC where an interim order is set to expire	This change will enhance the operational separation our investigation and adjudication functions.		Neutral	N/A	Yes
Section 2: Streamlining and modernising our hearing process					
Where we propose changing undertakings already in place and the doctor concerned does not agree, making clear that we can refer the matter to a panel for review	Given the overrepresentation of certain groups of doctors in our processes, this may disproportionately impact on these groups, however the numbers are likely to be very small.		Negative/Neutral	This is a necessary step in making sure the appropriate sanctions are in place to protect patient safety.	
Making clear that we can refer a doctor with undertakings to a panel for review where their language skills	This may disproportionately impact on groups of doctors with protected characteristics that are	The BMA commented that criteria, including the evidence required to show deterioration of English language, was necessary to mitigate against the risk of race or disability	Negative/Neutral	This is a necessary step in making sure the appropriate sanctions are in place to protect patient safety.	The aim of this proposal is to make sure we can take appropriate action to protect patients.

deteriorate or otherwise give risk to further concerns	overrepresented in our processes.	discrimination. We will provide guidance to decision makers when making referrals in these cases.		Actions: Decisions makers will be trained on unconscious bias and their role in making sure that procedures are fair. We will review and update current guidance for decision makers when making referrals to panels. We will make it clear in correspondence with doctors with undertakings that a referral to panel is possible in these circumstances.	
Streamlining our hearing process including: <ul style="list-style-type: none"> - identifying a doctor before hearing a legal argument) 	These changes will improve our hearing process, making it easier to follow and increasing the transparency of our decision	The MPS commented that the change regarding transcripts may be unfair for an unrepresented doctor who might not appreciate the importance of a hearing transcript.	Positive	N/A	Yes – this promotes transparency in our decision making and will streamline the hearing process, reducing the stress on everyone involved.

<ul style="list-style-type: none"> - making submissions and giving the reasons for a fitness to practise panel's decision at the fact-finding stage of a hearing - removing the need to refer to transcripts at review and restoration hearings 	making (allowing parties the opportunity to make submissions on the fact and for the panel to give their reasons for these decisions).	The MPTS factsheets for unrepresented doctors will be reviewed and updated.			
Making clear that the MPTS arranges recordings of panel hearings and the Registrar records hearings of the Investigation Committee and that on request the MPTS or the registrar can provide a written record.	This change will enhance the operational separation our investigation and adjudication functions.		Neutral	N/A	Yes

Clarifying the terminology we use, in particular what we mean by witness and that the GMC representative is the lawyer for the GMC.	<p>In future, a doctor will have to submit a witness statement as evidence-in-chief. This is likely to impact on those doctors with protected characteristics who are overrepresented in our processes.</p> <p>The hearing process will be clearer for all parties, including complainants and witnesses, some of whom may have protected characteristics.</p>	<p>One respondent noted that this may impact unrepresented doctors.</p> <p>See above.</p>	Positive/Neutral	This measure makes sure that evidence is appropriately submitted in each hearing, improving the efficiency of the hearing process.	Yes
Extending the power of the case manager and Investigation Committee members to adjourn hearings that are part heard when either party	This will reduce hearing time for all parties involved, including those doctors with protected characteristics who are overrepresented in	<p>The BMA commented that a doctor should not lose the opportunity to make representations to a panel about an adjournment.</p> <p>We have amended the rules to reserve a discretion for a case</p>	Positive	N/A	Yes

requests this.	our processes and complainants and witnesses, some of whom may have protected characteristics.	manager to refer an adjournment decision to a panel in certain circumstances.			
Extending a sanction where a review hearing is adjourned	<p>This may disproportionately impact on groups of doctors with protected characteristics that are overrepresented in our processes.</p> <p>This proposal will improve the effectiveness of regulation, enhancing confidence of the public generally, including those with protected characteristics.</p>	<p>Three doctors highlighted that this proposal may have an impact on a doctor's health.</p> <p>We are considering our approach to health cases as part of our work in response to the suicide review.</p>	Negative/Neutral	<p>This is a necessary step in making sure the appropriate sanctions are in place to protect patients.</p> <p>Action: Panellists will continue to be trained on unconscious bias and their role in making sure that procedures are fair.</p>	<p>The aim of this proposal is to make sure we can take appropriate action to protect patients.</p> <p>To the extent it enhances the confidence of the public, including those with protected characteristics, the proposal will foster good relations.</p>
Section 3: Making case management more effective					
Setting out that case management decisions will not be	This will allow panels the appropriate level	The BMA commented that the binding nature of case management decisions should	Positive	This is a relevant in mitigating the impact of the power to award	Yes

binding ie where it is in the interests of justice or where there has been a material change in circumstances	of flexibility in relation to taking action when a party has breached a case management decision benefitting doctors with protected characteristics who are overrepresented in our processes.	be made clear to unrepresented doctors. We will review and update MPTS factsheets for unrepresented doctors		costs (ie where a party has breached a case management decisions and behaved unreasonably) – see below.	
Setting out the process for: awarding costs, ie the panel decides at the end of a hearing after an application by either party; and assessing costs, ie a case manager will decide on the amount to be awarded based on information provided by the parties.	The power to award costs was introduced through changes to the <i>Medical Act 1983</i> consulted on by the Department of Health (England). The costs process may impact particularly on unrepresented doctors.	Five respondents thought special care should be taken in relation to unrepresented doctors and costs. See above. One respondent noted that costs awards may place pressure on a doctor who is unwell. We are considering our approach to health cases as part of our work in response to the suicide review.	Neutral	The costs process will enhance case management and make hearings more efficient. The process included in the rules aims to be clear and straightforward for all parties. Action: To draft guidance for panellists and case managers including how to determine unreasonable behaviour.	Yes, to the extent that, the process will support effective case management and potentially reduce hearing length. This will benefit all parties, including complainants and witnesses, some of whom may have protected characteristics.

Section 4: Removing the need for parties to attend review hearings

NB: This proposal was included in consultation conducted by the Department of Health (England).

Section 5: Making our investigation processes simpler and more effective

Removing the need to tell employers about provisional enquiries we make in order to decide if we need to carry out an investigation	<p>This will benefit those doctors with protected characteristics in our process by avoiding reputational damage before we have decided if a matter requires investigation.</p> <p>Public confidence in our process will be maintained as we will still be able to tell employers about a complaint where we need to.</p>	<p>One respondent said that cases involving health should be deferred if the doctor is undergoing treatment.</p> <p>We are considering our approach to health cases as part of our work in response to the suicide review.</p>	Positive	N/A	Yes – this will promote robust decision making.
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Section 6: Improving compliance and making assessments more effective

Providing the process for a new type of hearing, requiring no finding of impairment,	The powers necessary to introduce the new non-compliance process were	The Royal College of Anaesthetists suggested that the GMC find out if there are legitimate reasons for non-compliance (such as health).	Negative/Neutral	<p>This is a necessary step in making sure we protect patients.</p> <p>Non-compliance</p>	The aim of this proposal is to make sure we can take appropriate action to protect patients.
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where a doctor does not comply with a request to disclose information or does not engage with a performance, health of language assessment.	<p>included in the changes to the <i>Medical Act 1983</i>.</p> <p>This may disproportionately impact on groups of doctors with protected characteristics that are overrepresented in our processes.</p> <p>This proposal will improve the effectiveness of regulation, enhancing confidence of the public generally, including those with protected characteristics.</p>	<p>A small number of respondents also commented that the process may adversely impact doctors with health problems.</p> <p>We will develop guidance setting out the factors to consider when making a non-compliance referral to make sure we achieve a balance between protecting patient safety and the doctor's rights.</p>		<p>proceedings would only be pursued when the doctor had received a number of reminders asking them to comply and setting out clearly the consequences of non-compliance. A compliance order will be removed as soon as a doctor provides the required information/undertakes the requested assessment.</p> <p>Action: Panellists and decision makers will be trained on unconscious bias and their role in making sure that procedures are fair.</p>	<p>To the extent it enhances the confidence of the public, including those with protected characteristics, the proposal will foster good relations</p>
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Annex B

Individual respondents by gender, age and ethnicity

Gender	Number of individual respondents	Percentage*
Male	60	78%
Female	17	22%
	77	100

Age	Number of individual respondents	Percentage
Under 25	2	3
25-34	9	12
35-44	13	17
45-54	22	28
55-64	21	27
65+	11	14
	78	101

Ethnicity	Number of individual respondents	Percentage
White – English, Welsh, Scottish, Northern Irish or British	48	64
White Irish	3	4
White Gypsy or Irish traveller	0	0
Any other white background	4	5
White and Black Caribbean	0	0
White and Black African	1	1
White and Asian	1	1
Other mixed or multiple ethnic background	0	0

* Percentages are rounded up and may not total 100

Asian/Asian British – Indian	7	9
Asian/Asian British - Pakistani	1	1
Asian/Asian British - Bangladeshi	0	0
Asian/Asian British - Chinese	0	0
Any other Asian background	2	3
Black – Caribbean	0	0
Black – African	1	1
Any other black, African or Caribbean background	0	0
Arab	4	5
Any other ethnic group	3	4
	75	98