

General Medical Council Single Equality Scheme 2011 - 2014

Report on the Consultation to inform the development of the Equality Scheme

1. Introduction

This report presents the findings of the consultation exercise carried out by the General Medical Council (GMC) to inform the development of its Equality Scheme for 2011 – 2014.

The aim of the exercise was to seek views on the key equality themes, objectives and outcomes identified for the Scheme and to obtain feedback on any additional issues for consider.

The four key equality themes identified by the GMC were:

- Providing accessible information and services
- Helping doctors to provide high-quality care
- Being a fair regulator
- Using its influence to create positive change

The consultation ran from 3rd August to 15th October 2010.

Section 3 of this report identifies the key findings from the consultation exercise. Further details are provided in section 4.

2. Methodology

The consultation was in two phases and comprised of external and internal engagement activities.

A mixed methodology was adopted for the external consultation exercise.

The consultation was designed to gather both quantitative and qualitative data.

2.1 Phase One

Prior to launching the consultation the GMC actively sought the views of disabled people on how best to secure their involvement in the overall exercise and in particular, to identify how disabled people could be engaged.

The aim was to ensure that the views of disabled people were taken into account when designing the consultation and that proper attention was paid to ensuring its accessibility.

A letter went to 6 user led disability organisations across England, Wales, Northern Ireland and Scotland asking them to circulate a brief questionnaire to their members seeking views on the best ways to involve disabled people and what parts of the GMC's work were most relevant to them. The questionnaire was provided in Easyread and other formats were available on request.

2.2 Phase Two

The online questionnaire was hosted on the Community People website (the preferred host for GMC website consultations) with a link from the GMC home page. Online versions in Easyread and Welsh were provided.

The questionnaire offered respondents the opportunity not only to provide views on the appropriateness or otherwise of the four themes in the consultation, but also the chance to suggest additional themes and expected outcomes. Consultees were also asked if they wished to be involved in the work of the GMC and/or future consultations.

Copies of the online supporting documents and questionnaire are provided in Appendix 1 and 2.

A press release to publicise the online consultation was sent to 297 publications. In addition, a targeted email went to 230 organisations (92 in England, 48 in Northern Ireland, 58 in Scotland and 32 in Wales) to inform them of the consultation. Those targeted included patients and doctor groups, professional associations, the royal colleges, medical and education training bodies, statutory partners and equality and community organisations

In addition to the online questionnaire, around 100 organisations working across the range of Protected Characteristics were invited to attend a focus group.

The original plan was to have an online questionnaire and a series of focus groups with key stakeholders in the four nations. Unfortunately, despite extensive targeting, insufficient numbers responded to warrant holding focus groups in England, Wales and Northern Ireland and instead a number of face to face interviews were arranged. A focus group was held in Scotland.

To ensure that interested individuals had the opportunity to comment fully a supplementary questionnaire was made available to everyone who attended an interview or participated in the focus group.

The internal consultation exercise comprised a number of discussions with GMC staff to develop the initial key equality themes and an article in 'In Touch' (the GMC's internal magazine) alerting staff to the online consultation and encouraging them to give their views.

No formal responses to the consultation were received from GMC staff.

3. Key Findings

A total of 158 individuals/organisations contributed to Phases One and Two of the consultation.

3.1 Phase One

Two out of the six targeted organisations responded to the pre-consultation questionnaire.

One organisation, which focused on people with learning disabilities, circulated the questionnaire to its local membership groups. 34 responses were returned but it was not clear from the returns whether these were individual or composite responses (one response did say that the return was from 12 members).

The questionnaire responses indicated that face to face interviews were considered to be the best way of involving disabled people, particularly those with learning disabilities. Group discussion was rated as the second most effective way of involving disabled people. Using online and paper questionnaires had the lowest effectiveness rating. It was also recommended that for future consultations the GMC should go out to engage with user led and self advocacy groups.

The findings from the pre-involvement exercise were taken into account when designing Phase Two of the consultation. For example, respondents emphasised the importance of providing all consultation correspondence in accessible formats and so an Easyread version of the online questionnaire was provided and other alternative formats were available on request. The GMC asked about individuals access requirements to facilitate participate in focus groups and interviews.

The Phase One responses provided useful information, not only on the best way to involve disabled people, but also on issues and concerns regarding access and experiences of healthcare. For example, the problem of medical staff talking to a carer rather than the patient and a lack of awareness amongst doctors of how to work with people with learning disabilities.

Not all of the concerns raised by respondents fell within the remit of the GMC. For example, the recommendation that doctors should offer people with learning disabilities longer appointment times and that better training was needed for nurses to ensure that they treated people with learning disabilities with respect.

Nevertheless, a number of important issues were raised which have a bearing on the GMC's work, in particular in relation to setting standards in medical education and fostering good medical practice. Many of these issues surfaced again in Phase Two.

3.2 Phase Two

The opportunity to comment on the GMC's proposed equality themes was generally welcomed and there was considerable support for the priorities identified. Many respondents commented positively on the GMC's work to date on equality and diversity

3.2.1 Online questionnaire

A total of 84 responses were received. However, 6 of these contained no information relevant to the consultation and so are not included in the analysis. Very few of the respondents completed every section of the exercise and so the numbers vary from question to question.

Apart from substantive material on the themes and future work of the GMC, online respondents were asked to complete a consultee profile. Some individuals completed all questions, some only selected questions and a few, who were responding on behalf of an organisation, also completed some personal data fields.

3.2.2 Profile Summary of online respondents

Consultees were asked whether they were an individual or from an organisation, Of the 45 who responded to this question, 36, or 80%, were individuals and 20% responded on behalf of an organisation.

Fifty percent of the 42 who identified the category of respondent were doctors. Six (14.2%) were members of the public and others included a chaplain, medical managers, the third sector, a regulatory body, trade union and other health care professional.

88.6% (33) of those answering the question said their country of residence was England. There were four responses from Scotland.

There were 35 responses to the question about 'category of organisation' (which included some individuals who chose to state the organisations with which they were associated). Of these 19, or 54.3%, were NHS/HSC organisations, six represented doctors and four were from the third sector. Organisations were mostly based in the UK or England with four in Scotland and two covering both England and Wales. The majority of those who responded (n=16 out of 27 or 59.3%) said their organisation did not represent any particular equality strand. Four worked on ethnicity, two on disability, one each on religion or belief and gender and two covered all of the equality characteristics.

In terms of the equality profile, the majority of those providing their age were between the ages of 35 and 44 (n=13 out of 33 responses) with the next largest number of respondents in the 25-34 age range. 68.6% of respondents (n=24) were male and nine female (two preferring not to say) and all, with the exception of two who again preferred not to say, had the same gender identity they were born with. Four of the 35 consultees who responded (11.4%) indicated that they had a disability and a large majority (82.4%) were heterosexual. One respondent each declared themselves to be gay, bisexual and 'metrosexual' and three preferred not to say.

On ethnicity, there were 32 responses. Of these, the majority (53.1%) were Indian and 9 (28.1%) White British. Other categories were Black other (n=1) and any other ethnic group (n=1). Four individuals preferred not to say.

12, or 34.3% of the 35 who responded to the question on religion or belief were Hindu and 8 (22.8%) Christian. A further 20% declared that they had no religion. Other religions declared were Buddhist, Muslim and Sikh.

Appendix 3 provides a respondent profile of the online questionnaire and a summary of the key responses.

3.2.3 Summary of Online Consultation Findings

Consultees were asked whether the proposed themes, objectives and the outcomes would contribute to an effective framework for the Equality Scheme. These sections elicited the highest number of responses (between 60 and 75). Overall, the response was very positive with between 81.3% and 90.8% of respondents believing that the themes would contribute to an effective framework. The highest response rate was in relation to providing accessible information and services and the lowest for using the GMC's influence to create change.

The key findings have been grouped under the four key equality themes.

3.2.4 Theme 1 – Accessible information and services

There were very positive responses for each of the three outcomes under this theme – 88.7% (n=63) on fair, accessible and easy to understand complaints procedures; 88.7% (n=63) on accessible publications and communications; and 82.8% (n=58) on accessible registration and certification processes. In respect of the latter outcome 11.4% or eight respondents out of 70 indicated that they did not know.

Key messages were:

- The GMC should work collaboratively with the equality groups, developing its materials in partnership with them
- Information should be culturally appropriate and accessible and specifically address concerns about discrimination
- It is vital that the GMC is open and genuinely listens to the responses received from consultation.

3.2.5 Theme 2 – Helping doctors to provide high quality care

Of the two outcomes under this theme, ensuring that doctors understand the standards and ethics of UK practice elicited an extremely positive response (92.7% n=64) with views on the other proposed outcome on improving the quality of care for people with disabilities just slightly lower at 88%; 7.5% of the 67 respondents (n=5) indicated that they did not know.

Key messages were:

- There is a need for training and awareness raising amongst the profession on diversity, equality, inter-culturalism with equality and human rights embedded into medical training and more induction for doctors from overseas
- The GMC could work with the BMA and other representative organisations around the education and training of doctors
- Work on learning disabilities should reflect the diversity of disability, address consent issues and consider practice ethics where doctors may be from environments where there are different cultural attitudes to learning disability.

3.2.6 Theme 3 – Being a fair regulator

Responses to this theme and its three proposed outcomes were somewhat less positive although the vast majority still agreed with the proposed outcome. 75.4% [n=46] agreed with fair, transparent and non-discriminatory policies and processes; 77% [n=47] agreed with understanding the impact of policies on diverse groups; and 73.3% [n=44] agreed with enhancing understanding about fitness to practise). Those indicating either 'no' or 'don't know' were 24.6%, 23% and 16.7% respectively.

Key messages were:

- The GMC should consider and address the issue of disproportionality of international medical graduates in disciplinary matters
- Doctors facing disciplinary proceedings require support
- Disciplinary panels should have BME representation.

3.2.7 Theme 4 – Using the GMC's influence to create positive change

'No' and 'don't know' responses increased for this theme although, again, the majority were in agreement. 22.9% (n=14 of 61 respondents) did not feel that equality and diversity work makes a difference and improves outcomes and a further 9.8% didn't know. In relation to the proposal to raise awareness of potential barriers with partners to change things – 15% gave a negative response and 11.7% didn't know whether this was an appropriate outcome

Key message:

- Working with others, including statutory and other bodies in addition to BME doctors, could assist in understanding issues around the disproportionate numbers of international medical graduates/BME doctors involved in disciplinary matters.

3.2.8 Fulfilling legal obligations and involvement

The consultation exercise also asked respondents to indicate if they believed that the activities proposed would help the GMC to fulfil its legal obligations and, further, if they wanted to be involved in any of the work.

A minority of the 54 who responded to this question felt that the activities would help meet obligations with 42.6% saying they didn't know and a further 11.1% saying they would not. 28 consultees said they would like to be involved in this work.

3.3 Summary of key findings from the interviews, focus group and individual responses

There were twenty face to face interviews, three telephone interviews and one focus group with nine delegates (eight representing organisations and one individual service user). In addition, three supplementary questionnaires were received. In addition, seven organisations provided personal responses.

Appendix Four lists the organisations that provided feedback through these methods or chose to submit a personal response. Appendix Five provides an equality profile of these organisations.

The key findings have been grouped under the four key equality themes.

3.3.1 Theme one: Providing accessible information and services

- The GMC needs to raise its profile and improve understanding of its role and remit among patients and the public. Active engagement and involvement is key.
- The GMC should improve access to information and services through involving diverse user groups at the development stage.
- Alternative formats such as Easyread should be provided as standard and materials and information should take account of the Social Model of Disability.
- The GMC should make use of social media technologies to reach diverse patients and the public.

3.3.2 Theme two: Helping doctors to provide high quality care

- Equality and diversity should be a core assessed element of the curricula for doctors' medical education and training and continuing professional development. Evidence including experiential learning and assessment and training attendance results should contribute towards GMC decisions regarding revalidation, registration and licensing.
- Standards and Ethics guidance should be developed to include the range of protected characteristics, particularly trans, carers, sexual orientation and older age.

3.3.3 Theme three: being a fair regulator

- The GMC's regulatory function must be transparent and delivered by a representative workforce that is diversity and equality aware.
- Patients need to have improved understanding of rights and access to resolution routes including access to independent advocacy.
- Doctors should be made aware that contravention of equality and diversity incurs sanctions from the GMC.
- The Equality Scheme must explicitly address Fitness to Practise arrangements, especially as these are felt to be failing patients with a learning disability.
- The Equality Scheme must make explicit the need for medical professionals (and the GMC itself) to consider reasonable adjustments when delivering care (or adjudicating) for people with a learning disability.
- The GMC must take more account of the Human Rights Act and the Mental Capacity Act when considering cases.
- The GMC fitness to practise work could be an extremely powerful lever for changing healthcare practice.

3.3.4 Theme four: Using the GMC's influence to create positive change

- The GMC should use its influence with the royal colleges and other medical training bodies, healthcare quality assurance regimes, government and devolved administrations to improve patient access, experience and outcomes and support high quality care for diverse and marginalised communities.
- The GMC should engage a wide range of diversity stakeholders to drive improvements in healthcare practice.

3.4 Additional issues raised by respondents for consideration.

- Essential to ensure that there is leadership and full support for equality and diversity activities from the top of the GMC.
- The GMC should have a representative and diversity and equality aware workforce.
- Monitoring data should be collected, analysed and utilised by all functions to demonstrate impact and outcomes. It should be publicly available.
- Equality impact assessments should be mainstreamed to support data gathering, analysis and action.
- The GMC should adopt positive action to address under-representation and lack of participation in employment and services.
- There is a significant appetite among contributors to support and work with the GMC to realise its equality objectives and address specific diversity issues in the short and long term.
- It is important that everything the GMC does is governed by considerations of equality.
- More evidence is needed of what the consultation is trying to achieve above and beyond existing GMC and national guidance as well as what the GMC is doing on equality and diversity.
- Concern was expressed that the consultation had an undisclosed agenda, was not helped by asking 'closed' questions and the lack of detail on how outcomes would be delivered; however, another said 'well done!'
- Although the information in the consultation is thoughtful and considers the role of the GMC in promoting equality the tick box approach is not helpful and the response form doesn't enable capture of feedback.
- Without timescales for achieving outcomes it is difficult to hold the GMC to account and the organisation should constantly reflect on whether it is fulfilling its responsibilities.
- On the GMC as an organisation some consultees felt that it does not achieve its stated outcomes, is not fair or create positive change, has little insight into the real difficulties doctors face, has lost faith amongst BME doctors and needs to find a way to audit outcomes and ensure equality for doctors.
- One consultee suggested there should be an independent body to oversee the GMC's work.
- One consultee asked whether any disabled people or carers were in the 'driving seat' for this consultation, for example as members of a project board. It was also pointed out that it was vital to be open and genuinely listen to the responses received.

4. Detailed findings by theme

4.1 Theme 1 – Accessible information and services

4.1.1 Online consultation responses

The GMC was urged to work collaboratively with vulnerable groups and people with disabilities, developing its materials in partnership, including with carers. The views and voices of vulnerable young people needed to be heard and one respondent was willing to be consulted on matters relating to the Christian faith. A charity pointed out that it could only be effectively involved in consultation if it was paid for the input it made.

Mention was made of the need for the GMC to ensure that the information it disseminated was 'culturally appropriate and accessible to those with low levels of literacy'.

The GMC was praised for its leaflet on sexual orientation and it was proposed that this model is extended to other equality characteristics and that all GMC information is reviewed to specifically address concerns about discrimination.

One learning disabilities consultee noted the need for particular assistance, with Easy Read versions being crucial along with other types of support, such as advocates.

More research was needed to assess whether making a complaint was a 'struggle' for those with a learning disability and one consultee asked if a third party would be able to make a complaint on another's behalf.

4.1.2. Interviews, focus group and individual responses

The majority of respondents indicated that the role and remit of the GMC was not well understood by patients and the public. Consultees recommended that in future, the GMC should work to raise the profile of the organisation emphasising its regulatory function as well as the Registration, Revalidation, Standards and Ethics and Education and Training functions.

It was proposed that the GMC raises its profile through developing closer links with people with protected characteristics, including voluntary and community sector (VCS) representatives to develop and disseminate appropriate patient focused literature. A respondent indicated

'Everyone knows when and why to call 999. The GMC's profile should be the same'.

The majority of respondents indicated engagement and involvement of individuals with protected characteristics and their voluntary and community sector representatives was a key mechanism to ensure GMC information and services were appropriate, relevant and accessible.

'The GMC would gain a lot by engaging (children and young) people in the development of its information'.

While the GMC website was reported as 'good' by some consultees, the majority of consultees who commented on the website highlighted that many people with a range of protected characteristics do not have access to the internet and are digitally excluded; in particular older people, those with learning disabilities, those with visual impairments, migrants, new arrivals and those from deprived socio-economic backgrounds.

To facilitate access to the GMC website, disabled representatives indicated the need to ensure the website was triple 'A' compliant, had colour and font change functionality and was compatible with screen reading technology. VCS specialist organisations such as the RNID and RNIB had expertise in producing information for those who were Deaf, hard of hearing and visually impaired.

For some groups, such as those with learning disabilities, visual impairments, children and young people, frail elderly people, those whose first language is not English, GMC

information and services (including consultations) are not accessible without independent third party assistance.

“ to fully involve and engage people with learning disabilities takes time and proactive engagement with advocates and the authority to ensure people can engage in a meaningful way.”

Consultees recommended GMC information should be produced in Plain English and Welsh, and be made available in a wide variety of formats such as Easy Read, Large Print, Audio, British Sign Language and DVD to enable a broad range of people access to information and services.

Distributing information to VCS representatives and independent advocacy organisations, as well as GP surgeries, hospitals, Post Offices and other places such as Citizens Advice Bureaux, community centres and youth clubs, was needed to enable patients and the general public to understand the role and remit of the GMC, engage in GMC consultation activities, understand their rights and take action. This was particularly important when their doctor's fitness to practise was in question.

Guidance should signpost individuals to other agencies who might help them. Such guidance also needs to address patients' discriminatory attitudes to ensure vexatious complaints, such as those made about a GP's sexual orientation or gender identity, are eliminated.

The GMC might also use targeted media such as the Pink Press, DIVA and Attitude magazine to raise awareness with the Lesbian and Gay community; while providing editorial material to a range of VCS organisations would improve awareness and understanding for all protected characteristics.

Short educational films about the GMC's role and remit, specific pages for specific audiences e.g. children and young people and BSL users, as well as interactive content aimed at patients were felt to be mechanisms which would support improved information and access to services. GMC should also consider using new technologies, such as social networking, to engage and involve people as well as raise awareness.

Information relating to making complaints needed to be presented in easy steps, outlining the process in full, and the different roles and remits of the various health agencies which might deal with the complaint across the four nations.

It was recommended that GMC review all of its current information. Trans-gender issues were felt to be poorly represented and much of the information produced was felt by lesbian, gay and bisexual representatives, to be heterosexist. It was also important for the GMC to account for the different contexts in the four nations.

One respondent reported a case where a doctor had experienced difficulties when asking to be registered in their new gender identity. This was only resolved when a formal complaint was made. Trans organisations recommended that trans-people should be known in their preferred identity, whether they had a gender recognition certificate or not.

4.2 Theme two: Helping doctors to provide high quality care

4.2.1 Online consultation

The most positive response received during the online consultation (92.7%) was for the outcome to ensure that doctors understand the standards and ethics of UK practice. A number of consultees stressed the need for training and awareness raising and it was recommended that equality and human rights should be embedded into medical training. It was pointed out that medical staff need an enhanced awareness of the factors that *'can lead individuals to fear or suffer from discrimination'* with the example given of a practitioner who had publicly expressed negative views about homosexuality. There is a need for more induction for doctors coming from overseas, regular meetings and updates for junior doctors and international medical graduates including *'tips on how to avoid getting into trouble'*, training on diversity and inter-culturalism, awareness of religious, spiritual and cultural care and more education and training for doctors and students on safety, errors, risk, conduct and behaviour. The GMC was urged to work with representative groups in these areas.

Specific mention was made of the need to address gender discrimination in relation to non-therapeutic genital surgery for non-consenting children, an issue it was felt that puts doctors in very difficult positions.

Eight-eight percent of respondents to this theme agreed with the outcome to improve the quality of care for people with disabilities and the consultation exercise highlighted a number of particular issues relating to learning disabilities. Overall respondents stated that there is a need to raise awareness and develop skills, through practice, in this area and it was felt that the consultation theme was too general and did not reflect the diversity of disability. It was felt that doctors need a new set of skills to address where there may be professional bias that might operate to the detriment of patients and *'indifference'* to the needs and lives of people with disabilities; with all practitioners aware of learning disability issues including around consent. A particular issue identified was the level of understanding amongst doctors of UK practice ethics where they came from an environment where there were different cultural attitudes toward learning disabilities.

It was also pointed out that the notion of *'quality of care'* should be underpinned by an equality and human rights framework with human rights and equality law used to support patient rights and hold doctors accountable. Equality impact assessment was identified as a mechanism that can assist in achieving equality outcomes.

Finally, one consultee felt that there was a need to address bullying and harassment in doctors' training and practice.

4.2.2. Interviews, focus group and individual responses

This theme elicited the largest number of responses by consultees. The findings have implications for medical education and training, quality assurance, revalidation and continuing professional development and standards and ethics.

The majority of respondents who reflected patient and public perspectives reported examples of poor practice, inequitable, unfair, discriminatory treatment and barriers to access at local GP surgeries and hospitals. Health inequalities and differential health outcomes due to diversity factors were felt to be poorly understood by the profession.

The majority of respondents felt that access, experience and outcomes for patients could be improved by strengthening the equality, diversity and human rights elements of medical education and training pre and post qualification.

The GMC should specify curriculum content and require doctors to demonstrate good equality and diversity practice, including experience of direct engagement with patients and carers from diverse backgrounds which should form part of the assessment at the qualification stage. Such evidence should be required for validation, registration and license.

One respondent commented

“Generations of doctors, nurses and midwives are graduating without any specific knowledge of issues relating to sexual orientation, except in the narrow aspect of HIV prevention in gay men... When we speak to junior doctors they express concern about a general lack of understanding about how to talk to people from different backgrounds and how that affects good history taking and good judgement. We see in mental health a reticence to ask service users about their sexual orientation... although there are often clear connections between self harm and sexual orientation”.

Respondents felt that upon qualification, doctors should have awareness and experience of patient diversity, as well as knowledge of legal and policy based anti-discrimination and equality responsibilities as service providers, employers and as a ‘public authority’ due to the foreseen GP commissioning role outlined in the NHS White Paper. Some respondents indicated that the GMC should be *‘more vocal with the Royal Colleges’*

The GMC's quality assurance of medical schools should also be strengthened to ensure doctors' curricula includes equality, diversity and human rights. One respondent indicated that

‘Independent expert equality and diversity advice could support the quality assurance process’

Reference was made to issues over the selection of disabled candidates into medical schools. Guidance such as Gateways was felt to be a ‘positive initiative’ to improve representation among disabled medical students. Such guidance might be useful for other protected characteristics e.g. Trans.

A respondent from a disability organisation commented:

“Medical students should receive people skills training as well as “specialised” disability awareness (deaf awareness) and communication skills training throughout their medical education. This should not simply be a “one – off”. It should also be necessary for doctors to prove that they receive disability, equality and diversity awareness and assessment, and communication skills training as part of their CPD. This is something that could be regulated by the GMC – to ensure that doctors not only have the medical knowledge that makes them “fit to practise” but also the people skills necessary.”

A number of specific recommendations with regard to equality and diversity were made in relation to the content of medical education and training.

Many of these focused on the need to improve doctors’ awareness of such issues as:

- cultural sensitivities including Gypsy and Travellers and refugees and asylum seekers
- disability awareness particularly deaf awareness; learning disabilities, mental health and the Social Model of Disability
- age awareness in particular elder abuse, demographic change, and wider age discrimination
- the impact of religion and faith upon health and treatment including Christian, Islamic, Hindu and Judaism requirements
- the concept of holistic care in respecting the religious beliefs of patients, carers and doctors
- Trans-gender lifestyles, trans etiquette and access to referral
- Heterosexism, homophobia and sexual orientation
- carers needs, particularly the impact of waiting times upon carers and their own health needs
- sexual violence against women and female genital mutilation
- the power dynamic between patients and doctors
- socio-economic determinants of health
- dual identities and dual diagnoses
- disease prevalence and health inequalities for diverse groups
- how a doctor’s personal culture and beliefs can conflict with patients needs and requirements e.g. faith and sexual orientation, gender and race
- the need for smear tests and access to fertility treatment for lesbian women, quick access to sexual health screening for gay and bisexual men and the relationship between poor mental health and sexual orientation
- ‘diagnostic overshadowing’ for people with poor mental health, learning disabilities, transgender people and those in older age groups
- ‘Cost – benefit’ analyses restricting access to treatment for disabled and older aged patients
- the lack of take up of consultant or hospital referrals by black and minority ethnic patients
- Equality Impact Assessment, participation, engagement and involvement techniques

- Respondents also said that content should where possible, be delivered by patients/ service users themselves.
- Interactive web based learning tools were felt to be particularly useful to raise awareness and support training of doctors, as one Doctor commented.

“A leaflet is not training”

The majority of respondents indicated that equality, diversity and human rights training should be a core element of continuing professional development and should inform the revalidation framework and process. This was particularly important as legal rights, responsibilities and the policy framework changed regularly. A learning disabled respondent reported

‘Although Valuing People Now makes it clear that disabled people should have longer appointment times, this is not well known by doctors or receptionists’.

Revalidation and relicensing was felt to be beneficial to all patients and service users, with most agreeing that revalidation was a welcome development which would improve outcomes for patients, particularly as

‘Doctors have patients lives in their hands... it does not seem right that they should have a life time qualification.’

Many respondents felt that patient satisfaction ratings should inform revalidation decisions.

Respondents were mindful that revalidation should not indirectly or directly discriminate against older doctors, women, carers, transgender, those experiencing health conditions or disabilities.

The GMC should highlight examples of good practice, where doctors had got it right, as these are useful to illustrate the range of practical problems and demonstrate solutions which impacted upon high quality patient care.

It was strongly felt that existing patient and doctor networks, the VCS and individuals from diverse groups should be actively engaged to develop such guidance and that some useful resources, such as ‘Hindus and Healthcare’ were already available to inform the GMC’s work.

The ‘love my neighbour’ faith based ethos was thought to be a useful guiding principle for doctors.

The majority of respondents felt that doctors interpersonal skills could be improved with emphasis on good communication skills including active listening, using plain language which lay persons can understand and checking understanding of diagnoses and treatments as well as communicating in a dignified and respectful manner.

‘Often discrimination starts when a doctor is dismissive of a person’

‘ You don’t need a session on let’s talk about gay stuff you need a session on how to ask open questions’

“Doctors need to communicate in a manner that is not God to Man”

Where prescribed medication names changed it was particularly important for doctors to communicate this effectively to people with learning disabilities and poor mental health.

'My own GP and surgery receptionists often accuse me of wasting time if I query why my medicines have different names. My GP has said to me ' I have 365 patients ... stop wasting my time'

Communication between hospital Consultants, GP's and patients was also felt to be an area for improvement, particularly when it came to liaising about disabled peoples conditions. A respondent with a learning disability commented:

'We have to ask the consultant to copy us into any letters sent to our GP. We then wave our copy at them when we visit the surgery. It's the only way we can be assured they have read the Consultants' opinion'

A wide range of respondents, including those from black and minority ethnic backgrounds, agreed that overseas doctors should be required to have a high command of English, including the use of colloquialisms. One commented:

'Doctors need to be able to speak good English. Someone's life is depending on it. The GMC should not be apologetic that it is asking for a high level of skills in this area.'

It was felt that the lack of language testing for doctors from the European Union was impacting on delivering high quality patient care.

As well as the need for a high level of English language, it was felt that it would be helpful for all doctors to be tested on a regular basis to show their awareness of the communication needs of patients with disabilities and the auxiliary aids available to meet such needs.

Improving overseas doctors' awareness of standards and ethics applicable in the UK and ensuring a robust induction were also felt to be activities which could improve care and prevent fitness to practise cases.

All doctors irrespective of where they qualified, should, when placed in a practice, undergo an induction into the area to enable improved understanding of socio-demographics, the community context and history. This would improve doctors' understanding of patients and the operating environment. This was particularly pertinent for respondents in Wales.

Many respondents felt that doctors' practice could be improved through direct engagement and involvement with service users. Doctors should be encouraged to work together with service users to identify issues and develop appropriate responses to remove barriers and improve access and experience. This would also help GP's to meet their obligations when they became commissioning agents for NHS services in future.

"Doctors have to have more contact, more active listening, not just which box the person fits into"

The surgery environment was noted as presenting particular barriers for people, notably a lack of physical access, receptionist and other healthcare professionals' attitudes and the need for communication support for disabled people including BSL and other people whose communication was impaired. Longer appointment times for those with learning disabilities, longer opening hours and more flexibility around appointments was reported as needed.

While some respondents felt that people accessing healthcare services should speak English, many felt it was necessary to provide access to independent translation services for those whose first language was not English to enable confidential participation. Relying on family members to provide interpretation or translation facilities was reported as inhibiting frank and open discussion, particularly for ethnic minority women when it came to fertility and sexual health and sexual or domestic violence problems.

The lack of same sex-doctors or doctors from different ethnic backgrounds also inhibited access and experience for older women, lesbians of all ages, ethnic minority women, some refugees and asylum seekers.

The long hours culture of doctors was felt to particularly endanger patients and it was felt that the GMC should lobby to ensure the European Working Time Directive applied to trainee and qualified doctors.

The importance of flexibility with regard to training was raised, as was support for doctors who wish to work flexibly.

Transgender respondents reported a 'postcode lottery' when it came to accessing gender identity and reassignment surgery, with good services subject to oversubscription. This had resulted in many transgendered people travelling overseas to have operations if finances allowed, or slipping into depression, unemployment and homelessness while waiting. Those professionals who worked with trans should have more status in the profession and it was suggested that the GMC should appoint a trans-champion who could assist with problems or queries. While a range of materials were available to improve access, experience and outcomes for trans- people, drawn up by the Department of Health, these were not being used in practice. The GMC could review and update these with trans-representatives with little cost.

Respondents in Scotland, Wales and Northern Ireland indicated a need to understand how rurality could impact upon access to services and that the GMC should try and influence improvements for rural areas.

Specifically in Wales the GMC might work with other stakeholders to improve the retention of Welsh junior doctors in Wales.

It was felt that the GMC might use its influence with a range of stakeholders across the United Kingdom, to secure appropriate resources, to address any system failings preventing the delivery high quality patient care.

4.3 Theme three: Being a fair regulator

4.3.1 Online consultation responses

On this theme around one quarter of respondents indicated either 'no' or 'don't know' answers in relation to the outcomes proposed. Additional comments reflect a range of views about the GMC's fitness to practise procedures and the need for support for doctors generally. The need to consider and address the question of disproportionality of BME doctors being involved in such hearings as well as a call for hearing panels to include BME representation in disciplinary cases involving international medical graduates were highlighted. Consultees felt that doctors 'in difficulties' needed support services and sympathy and that the GMC should include a support role in its remit alongside that of being a regulator given 'the devastating effect the GMC can have on doctors'. The disciplinary process should not be tainted by 'personal prejudice', ambiguity should be eliminated and plain English used and it was suggested that there was a role for local employers to play in relation to addressing some errors rather than via the fitness to practise process and that mistakes should be considered against the 'universal context' rather than in isolation. As one respondent put it, doctors should not be punished for 'systems failures'.

4.3.2. Interviews, focus group and individual responses

Two of the most frequently cited responses to this theme was that there was a need for investigators and panellists to have a good understanding of equality and diversity issues and that staff involved in fitness to practise cases should be diverse.

Ongoing and regular training should be delivered to investigators and panellists, particularly in relation to trans, sexual orientation and carers. Investigators and panellists should understand the impact of dual identities e.g. ethnicity and gender upon perceptions of harassment.

Recruitment of panellists should account for reasonable adjustments and it was felt that fitness to practise investigators and panellists should consider whether a doctor has made reasonable adjustments when delivering healthcare to someone with a learning disability as part of the fitness to practise case.

It was felt that the GMC needs to make it clear that the regulation function understands and accounts for the diversity of patients and doctors and is transparent. It is not only necessary for the GMC to be transparent; the GMC has to be seen to be transparent. Some respondents thought equality impact assessments and an independent external advisory proportionality panel, such as that used by South Wales Police, should be implemented to support investigators and panellists in fitness to practise cases.

Most respondents felt that because the GMC was only publicly referred to in cases where things had gone horribly wrong, this resulted in a negative perception of the regulatory function among the public and doctors. Respondents felt that fair, transparent judgements and demonstration of GMC action using lessons learned from fitness to practise cases, should be publicly available.

Where possible, the GMC should try and work with the media to reduce fears that cases would result in lesbian, gay, bisexual and trans-gender people being 'publicly outed' and to better balance anonymity and the public interest.

The third most frequent response to this theme was the need for patients to have a better understanding of their rights and expectations from doctors, including access to independent advocacy when a complaint of fitness to practise arose.

A number of respondents indicated that there remained barriers to making and pursuing complaints for individuals, including for those with learning disabilities, poor mental health, the elderly, children and young people, migrants, those with low literacy levels and lower standards of education. Trans, lesbian, gay and bisexual people were reported as reluctant to make complaints due to fears regarding confidentiality and 'being outed'. Trans people were also unlikely to make a complaint due to fear that a doctor with trans-expertise would not be replaced if that particular doctor was struck off. They would rather 'put up and shut up' than lose services. A trans representative reported

'Research showed that 800 people received abuse in one clinic but only one person complained.'

The failing of fitness to practise arrangements, especially where the complaint against a doctor is in connection with the treatment of a patient with a learning disability, was highlighted. For example, where cases relating to the death of a relative with a learning disability had been referred to the GMC, it was noted that no individual doctor had, to date, been held accountable for their individual failings. This had led to a perception among those bereaved families that the GMC places a higher importance on doctors' careers than on the lives of people with a learning disability.

At hearings disabled representatives stressed the need for reasonable adjustments for all parties and other practical suggestions to facilitate witness involvement.

Other practical suggestions to facilitate witness involvement included providing pre and post case support; providing funding to support childcare, carers, transport and travel costs, particularly for those on low incomes; and providing translation services and access to advocacy where appropriate. Both parties to a complaint should have equitably skilled representation.

As well as recognising where a doctor's personal beliefs could impact in fitness to practise cases e.g. faith and sexual orientation, it was necessary for the GMC to minimise vexatious complaints resulting from discriminatory beliefs among patients e.g. sexual orientation or trans.

"A lot of gay doctors who are improving health outcomes get complaints about them because they have appeared in Gay Times'.

It was strongly felt that the GMC should be working with patients, GPs, medical schools and the royal colleges, and the NHS to *'prevent fitness to practise cases from arising in the first instance.'*

Some respondents mentioned that there was a continuing recognition that doctors from ethnic minority backgrounds are over-represented within the Stream 1' referrals, especially from 'bodies acting in a public capacity' such as the police and NHS authorities.

A number of comments were made regarding the fitness to practise process and the need for this to be conducted as speedily as possible for the benefit of all parties.

Doctors should be made aware that failure to observe anti-discrimination and equality measures could result in sanctions.

Gathering and analysing the full range of monitoring data of those who made and were the subject of fitness to practise complaints was regarded as key by a significant number of respondents. Without such data and analysis it was difficult for the GMC to prove that it was acting transparently. Such data would also support GMC to work in a preventative fashion.

4.4. Theme 4 – Using the GMC's influence to create positive change

4.4.1 Online consultation responses

This theme elicited the least number of positive responses about the two proposed outcomes: that equality and diversity work makes a difference and improves outcomes and to raise awareness of potential barriers with partners although a significant majority of respondents did support these activities. Additional comments recommended that better working relationships should be built with doctors, including those from a BME background and those trained overseas, and that working with statutory and other bodies such as the Department of Health, colleges, deaneries and professional organisations could assist the GMC in understanding issues around the disproportionality of BME doctors involved in disciplinary matters. Within the profession there was a plea to help ensure that women GPs were not seen as 'more expensive', for example, in terms of maternity pay and leave, particularly in the current economic times.

4.4.2. Interviews, focus group and individual responses

A large number of respondents felt that the GMC should better engage individuals and representatives from across the range of 'protected characteristics' to identify barriers and issues for patients. This involvement should be used to influence GMC stakeholders across the United Kingdom.

It was felt that the GMC should use its influence in particular to improve patient care and prevent fitness to practise cases by strengthening equality and diversity in standards and ethics, medical education and training.

Respondents felt that GMC should be more proactively engaged in responding to government and VCS policy and research which impacted upon equality and diversity, and should use its influence to raise awareness of those most marginalised in society. A number of opportunities such as the Patients Rights Bill in Scotland, the Mental Capacity, Health and Welfare Bill in Northern Ireland, and the NHS White Paper, were currently available to the GMC. In each instance the GMC should be reflecting the needs of patients.

Where formal investigations were conducted by the Equality and Human Rights Commission or the Equality Commission for Northern Ireland or the Older Persons Commissioner in Wales, the GMC could take on board findings and follow up through research with Doctors and patients. For example, the GMC could try and establish from GP's the number of learning disabled people registered in their practices.

The majority of respondents welcomed the opportunity to contribute to the development of the Equality Scheme. In the main respondents indicated that they would like to work with the GMC on an ongoing basis and could support the GMC in a number of ways including sharing equality, diversity and human rights expertise with the four nations perspective; providing access to users at a grass roots level to disseminate information; raise the GMC's profile; facilitate involvement and engagement including consultation events; developing guidance and best practice for GMC staff, doctors and the royal colleges; delivering training for GMC staff and doctors; supporting the development of the revalidation framework; sharing research; proofing policies and commenting on language.

Some contributors felt there was merit in bringing together the health and social care sector to join up their equality and diversity activity, develop consensus on outcomes between organisations and align their equality schemes.

Respondents provided details of over 50 additional organisations representing the range of protected characteristics the GMC might work with to deliver initiatives linked to the Equality Scheme.

It was felt a representative external and independent equality and diversity advisory group could help to support the GMC to monitor developments and progress. Regular meetings with practitioners and representative bodies for specific issues, such as trans, would be welcomed.

'Organisations like the GMC should have formal stakeholder representatives. At least twice a year they should call in stakeholders, including practitioners and nursing staff and have a proper consultation. Not just any old patient – why presume one person will be able to represent the community.'

While a representative independent advisory equality and diversity advisory group was favoured, some respondents felt that many groups should be engaged with the GMC on a task basis e.g. to develop information for children and young people, to develop guidance for doctors about the treatment of older people and trans people etc.

4.5 Additional findings

4.5.1 Being an employer of choice

The majority of respondents to this theme, indicated that GMC should aim to have a representative workforce and that this should be proven through the publication of workforce monitoring data and analysis.

A wider more diverse pool of applicants could be attracted to the GMC if the organisation disseminated vacancy details to the range of VCS organisations such as those taking part in the consultation.

Diverse staff representation would assist the GMC to develop a robust knowledge base and mainstream equality and diversity across all functions in practice.

Where under-representation occurred, respondents felt that the GMC should use positive action measures, such as the current Management Diploma which is used to improve women in leadership positions.

It was felt that the GMC should adopt practices which were more favourable for disabled people such as supported employment opportunities, encouraging early disclosure of disability and proactively providing reasonable adjustments, in addition to signing up and implementing the Two Ticks guaranteed interview scheme.

Considering the needs of carers and providing flexibility where possible to all staff would better support GMC to ensure there was no discrimination due to association.

It was felt that there was a need for improved understanding of the Gender Recognition Act and the difficulties transgender employees faced at recruitment and selection. Regarding trans people there is *'a need for clear policies'* in respect of employment.

External benchmarks such as Race for Opportunity, Opportunity Now and Stonewall Diversity Champions were felt to be useful tools to support GMC to develop inclusive employment practice and to become a recognised employer of choice.

Staff networks, particularly for lesbian, gay, bisexual and trans staff were felt to be useful tools to identify barriers and develop employment practice. Where possible, the GMC should use the knowledge and expertise of staff with protected characteristics to advise on equality and diversity as it applies to the GMC as an employer, a service provider, regulator, standard setter and educator.

One respondent commented

"Our impression is that the expertise of lesbian and gay GMC staff is not feeding into the communications strategy and this is a gap."

Specifically the GMC should work to remove enforced retirement, in preparation for the phasing out of the national default retirement age in 2011.

4.5.2 Improve the quality of monitoring data

The majority of respondents commenting on data and monitoring emphasised the need for diversity and equality data gathering, collation, analysis and utilisation across all functions if the GMC was to identify diversity and inequality issues and demonstrate progress towards achieving equality of outcomes.

Data should be collected from employees, service users, patients, GPs, investigators and panellists involved in fitness to practise complaints, customer complainants, those involved and engaged in consultation, involvement and engagement. To assist transparency, monitoring data should be made publicly available. A carers representative commented

“It would be interesting to know how many carers and the diversity of the carers that responded to the GMC’s recent child protection consultation – carers of disabled children will have very different views to carers of children from BME backgrounds’.

Monitoring should cover all protected characteristics. Sexual orientation representatives described the ‘need to collect data on sexual orientation in employment, fitness to practise and complaints, registration and revalidation.’

Trans, disabled and lesbian, gay and bisexual respondents emphasised the need to explain why such data was being collected and that such data was safe and secure to invoke confidence of employees, service users, and complainants.

Respondents felt that medical schools should also be required to report on a wide range of diversity data and demonstrate diversity and equality analysis and utilisation as part of the quality assurance process. Data should demonstrate a diverse and inclusive student and professional’s base and curricula.

Respondents indicated an equality impact assessment was a preferred method to demonstrate data collection and analysis by the GMC. Equality impact assessments should where possible include human rights and should be widely used to embed and mainstream equality, diversity and human rights culture and practice. Such a mechanism was felt to be able to sustain progress towards equality *‘if action driven by particular individuals was lost.’*

4.5.3 Build the capacity of our staff in understanding equality and diversity issues

In addition to facilitating and providing a range of training opportunities for doctors, respondents indicated that GMC staff should have a full and in-depth training programme to raise awareness of prejudices and assumptions for all protected characteristics, particularly for less well known equality groups such as age, trans, sexual orientation, learning, physical and sensory disabilities, mental health and carers.

Such training should also equip staff to be aware of the different equality contexts in each of the four nations, for example, religion and belief discrimination has a different profile in Northern Ireland, England, Scotland and Wales.

Training should equip staff with competence in equality impact assessment, data analysis and utilisation. Staff training should also outline the new provisions and enforcement of the Equality Act 2010 as it phases in to 2013/14.

Where possible the GMC should use trainers with protected characteristics to raise awareness and share expertise such as trans, gender and age equality proofing. Many of the respondents had guidance and training materials and would be able to facilitate training for the GMC.

Training should be interactive and, where possible, use new technologies and new formats, such as forum theatre currently being developed to improve GPs interaction with learning disabled people.

4.6 OTHER FINDINGS

4.6.1 The Equality Scheme.

- Consultees felt that the language of the Equality Act 2010 should be reflected in the GMC's Scheme.
- The Scheme should make clear and explicit reference to all protected characteristics with the 'diversity inherent in each' recognised. Particular attention should be paid to gender, carers, trans- men and women and age.
- One organisation pointed to '*a significant lack of addressing matters pertaining to ethnicity, race, culture, faith and belief*' whilst others urged the use of the term 'disabled people' rather than 'people with disabilities' and a greater emphasis on 'building consultation and co-production' with people from different equality groups.
- Although not a Protected Characteristic, it is important to include carers within the equality themes, outcomes and activities.
- The Equality Scheme should include SMART objectives which deliver clear outcomes specific to protected characteristics.
- The majority of contributors emphasised the need for the GMC to demonstrate progress to deliver outcomes over time.
- The Scheme should tighten up on potential gaps identified in the consultation document and examples of activities.

5. Next steps

The GMC would like to thank all of those who participated in the consultation exercise.

The findings are being used to inform the action plan for the new Equality Scheme, a draft of which will be produced in January 2011. We will invite further comments on the Scheme's plan at this time.

The final Scheme will be approved by the GMC's Council in April 2011 and will be published on the website.

APPENDIX ONE

ONLINE QUESTIONNAIRE

General Medical Council (GMC) Equality Scheme 2011 – 2014 Consultation

Consultation Summary

The GMC is seeking views on the themes and objectives it has identified to support the development of a draft Equality Scheme for 2011-2014.

Background

We are bound by legislation to produce Equality Schemes for disability, gender and race to outline how we will fulfil our equality duty obligations. These duties require us to have due regard to:

- Eliminate discrimination
- Promote equality of opportunity
- Foster good relations
- Promote participation of disabled people
- Promote positive attitudes towards disabled people
- Take account of a disabled person's disabilities even if this means treating disabled people more favourably.

We are also required to fulfil legal obligations under existing legislation for age, sexual orientation and religion or belief.

Our approach to the preparation of our Scheme has been to engage with staff across our directorates and functions to identify key areas that require attention and that are critical to us meeting our statutory duties.

The consultation sets out our initial thinking following this internal work. At this stage we have chosen to present our thoughts in a thematic way rather than produce a draft final Scheme as we believe this gives us more flexibility in terms of taking on board the views of consultees.

We will take account of the views received to develop a draft Equality Scheme which will go to our Council for approval in January 2011.

We are also running a series of engagement events aimed specifically at the public and patients across the six equality groups of age, gender, disability, religion or belief, sexual orientation and race. These will be held in England, Northern Ireland, Scotland and Wales in September 2010.

In line with our legal obligations, we have sought to involve disabled people and obtain their views on how we should consult.

Please refer to the background document (below) for more information about equality and diversity at the GMC.

Purpose

The purpose of the consultation is to gather views on whether the proposed themes, outcomes and activities that we have identified will deliver equality outcomes in practice.

The closing date for the consultation is Friday 15 October 2010.

Further Details

This is an on-line consultation. The consultation documents can be provided and submitted in alternative formats. Please contact Elaine Bromberg to discuss your requirements in more detail:

Contact

Elaine Bromberg

Equality and Diversity Manager

Email: equality@gmc-uk.org

Telephone: 020 7189 5420

Textphone users. Please use the Text Relay Service: Dial Prefix **18001 + 020 7189 5420**

Background - Equality and Diversity at the General Medical Council

Who we are

1. The General Medical Council (GMC) has four main functions:
 - a. keeping up-to-date registers of qualified doctors
 - b. fostering good medical practice
 - c. promoting high standards of medical education
 - d. dealing firmly and fairly with doctors whose fitness to practise is in doubt.
2. We are the independent regulator for doctors in the UK. We do this by:
 - a. controlling entry to the medical register
 - b. setting the educational standards for medical schools
 - c. determining the principles and values that underpin good medical practice
 - d. taking firm but fair action where those standards have not been met.
3. We are not here to protect the medical profession - their interests are protected by others. Our job is to protect patients and we have strong and effective legal powers designed to maintain the standards the public have a right to expect of doctors.
4. Where any doctor fails to meet those standards, we act to protect patients from harm - if necessary, by removing the doctor from the register and removing their right to practise medicine.
5. Patients' interests are best served by independent, accountable regulation. The GMC must be independent of government, as the dominant provider of healthcare in the UK, free from domination by any single group and publicly accountable for the discharge of our functions. This means that we will:
 - a. put patient safety first
 - b. support good medical practice
 - c. promote fairness and equality and value diversity
 - d. respect the principles of good regulation: proportionality, accountability, consistency, transparency.
6. The GMC is structured around five Directorates which are:
 - a. Standards and Fitness to Practise
 - b. Education
 - c. Continued Practice and Revalidation

d Registration and Resources

e Communications

and a unit, Strategy and Planning.

7. A brief overview of each is at **Appendix 1**.

Roles and responsibilities

8. Paul Philip, Deputy Chief Executive, is our 'Senior Sponsor' for equality and diversity. He ensures that diversity issues are considered by Directors and Council as part of every relevant decision making process.

9. Equality and diversity champions within each directorate assist in further embedding equality and diversity within our procedures, processes and practices.

10. The lead staff responsible for equality and diversity are Andrea Callender, Head of Diversity, and Elaine Bromberg, Equality and Diversity Manager.

11. The Equality and Diversity Reference Group meets quarterly and is formed of four Council members and a number of senior staff. It contributes to developing, embedding and further enhancing our approach to equality and diversity.

Our Equality Duties

12. Currently we have general duties on gender, disability and race to:

a eliminate discrimination and harassment

b promote equality of opportunity

c promote good race relations

d promote positive attitudes to disabled people

e encourage the participation of disabled people in public life

f take account of a disabled person's disabilities even if this means treating the disabled person more favourably.

13. We are also committed to equality and diversity in relation to age, religion or belief and sexual orientation and this will be reflected in our Equality Scheme.

14. In 2010 Government passed the Equality Act. Once the law is in place we will review our Equality Scheme and adjust it, as necessary, to take account of the new provisions.

15. You can view our existing Scheme, which runs until the end of 2010, at http://www.gmc-uk.org/about/equality_scheme.asp. The Scheme and its action plan summarises the work that we have undertaken over the last three years.

Our Achievements

16. We have made considerable progress to address equality and diversity issues over the past three years across all of our functions.
17. Examples of our work on equality and diversity include:
 - a Through the 'Gateways to the Profession' initiative we developed guidance for medical schools on how to improve access for disabled students
 - b We concluded research into the perceived over-representation of international medical graduates in our fitness to practise procedures
 - c We provided training and briefings on relevant equality and diversity issues for Fitness to Practise panellists and legal assessors
 - d We undertook a comprehensive consultation exercise on proposals for the revalidation of doctors targeting black and minority ethnic doctors, women, gay and lesbian doctors and those representing different religious faiths
 - e We worked closely with refugee and asylum seeker support organisations to address the challenges faced by this group of doctors
 - f We adapted our Gender Recognition Policy to remove obstacles faced by doctors wishing to change their gender
 - g We ended the age exemption from the annual doctors' registration fee
 - h We undertook a review of our recruitment and retention policies to ensure selection procedures reflect good practice.

Our Vision

18. Our vision for where we want to be as a result of our work on equality and diversity is about enhanced confidence and recognition of our leadership in this area:
 - a. Absolute confidence that we are fair and non-discriminatory in how we regulate, and that our systems and guidance are free from bias and transparent to all of our interest groups.
 - b. An inclusive organisation that uses our influence to tackle inequalities and create positive change.
 - c. An employer of choice for the most talented people from all sections of society.
 - d. An organisation that is recognised as a leader for our good practice by other influential entities and diverse stakeholders amongst our key interest groups.

Appendix 1 - General Medical Council Directorates

Standards and Fitness to Practise

1 The GMC has a statutory role to provide guidance to doctors on standards of professional conduct, professional performance and medical ethics.

2 The Standards and Ethics function sets out the values and principles that underpin good medical practice and describes how the principles can be applied. This helps doctors to provide good care and to respond to the complex ethical problems they may face in their professional lives.

3 The Fitness to Practise function deals firmly, fairly and speedily with those doctors who fail to maintain the standards expected of them. This involves the investigation of concerns raised about individual doctors and, if the investigation calls into question the doctor's fitness to practise, the adjudication of cases before a Fitness to Practise Panel. In addition, we undertake active monitoring to ensure that restrictions imposed on a doctor's registration are being met.

Education

4 One of our core legal functions is the regulation of education and training for medical students and trainees.

5 The Education Directorate sets standards and requirements that must be met by all UK medical schools. It is also responsible for checking that these standards and requirements are met, through our quality assurance programme.

6 The GMC is responsible for the regulation of education and training for all stages of a doctor's career – from admission to medical school, through postgraduate training, to continued practice until retirement.

Continued Practice and Revalidation

7 This directorate is responsible for policy and implementation concerning doctors' continued practice. This responsibility includes developing and supporting the delivery of revalidation across the UK.

8 The introduction of revalidation will fundamentally change the way doctors within the UK are regulated. The purpose of revalidation is to assure patients, employers and other healthcare professionals that licensed doctors are up to date and are practising to the appropriate professional standards.

Registration and Resources

9 The overall objective of the Registration function is to ensure the highest standards are maintained in the processing of applications for entry to the Medical Register, and that only those doctors who are suitably qualified and fit to practise gain registration. We play a key role in providing appropriate advice and guidance to customers who contact us.

10 The work of the Resources function underpins the work of the rest of the organisation. Resources teams ensure that the GMC is kept running smoothly. Areas of work include Human Resources, Facilities, Finance, Procurement and Information Systems.

Communications

11 The Communications Directorate's job is to engage and maintain strong links with our four key interest groups, the media and politicians across the UK as well as our Council members and staff.

12 Our Directorate is the base for communications advice and support to policy teams; the devolved offices in Scotland, Wales and Northern Ireland, external relations, media relations, public affairs, publications, the web and internal communications.

Strategy and Planning

13 The Strategy and Planning Unit is the central co-ordination unit which provides a link between the five Directorates, the Chief Executive, and Council. It ensures that the GMC is well-governed with a clear purpose, strategy and plans; that policy-making and decision-making processes are consistent, fair and well informed; and that we have a coherent and robust approach to business planning, monitoring and reporting.

14 The Unit has six teams covering planning, the Office of the Chair and Chief Executive, Governance, Equality and Diversity, European and International Development and Strategy and Analysis. Each of the teams provides input into engagement with the GMC's key interest groups, an evidence base to support decision making and evaluation, governance processes, risk management, strategic planning and equality and diversity.

General Medical Council

Equality Scheme 2011 – 2014 Consultation

Establishing our priorities

1 In consultation with our staff, we have identified several possible themes for our Equality Scheme.

- a Theme 1: Providing accessible information and services
- b Theme 2: Helping doctors to provide high-quality care
- c Theme 3: Being a fair regulator
- d Theme 4: Using our influence to create positive change

2 Below are set out some examples of activities and outcomes to help us to deliver on each theme.

3 The themes, outcomes and examples of activities are for illustrative purposes and are not exhaustive.

Theme 1: Providing accessible information and services

4 What we want to achieve

- a A complaints process which is fair, accessible and easy to understand.
- b Our publications and communications are accessible and reflect good practice.

c Our registration and certification processes are accessible for doctors.

5 What we might do

a Do more work to understand who brings complaints to the GMC.

b Continued testing and development of our website to enhance its usability and accessibility.

c Review how we publish materials in alternative languages and accessible formats.

d Review our registration arrangements for doctors.

Theme 2: Helping doctors to provide high quality care

6 What we want to achieve

a Improve the quality of care that people with disabilities receive from their doctors.

b Enhance patient safety by ensuring that all doctors understand the standards and ethics for practising in the UK.

7 What we might do

a Produce materials and resources to raise awareness of the needs and experiences of patients with learning disabilities.

b Explore how we can raise the awareness of doctors who qualify overseas about the UK's medical standards and ethics.

c Enhance engagement with diverse groups of doctors.

Theme 3: Being a fair regulator

8 What we want to achieve

a Ensure that our policies, processes and procedures are fair, transparent and non-discriminatory.

b Understand the impact of our policies and processes on diverse groups of doctors, patients and service users.

c Enhance the understanding of doctors, patients and the public about our Fitness to Practise procedures.

9 What we might do

a Explore the feasibility of establishing user groups to inform our policy and decision making.

- b Ensure that anyone involved in Fitness to Practise procedures are aware of the relevant issues that may apply to diverse groups of witnesses and doctors.
- c Track the perceptions of diverse interest groups (including doctors, patients and service users) about our Fitness to Practise procedures.
- d Do more work to understand any differentials of outcomes for diverse interest groups.

Theme 4: Using our influence to create positive change

10 What we want to achieve

- a Our work on equality and diversity makes a difference and improves outcomes for diverse groups of people.
- b We raise awareness of potential barriers with our partners and other influential organisations to help to change things for the better.

11 What we might do

- a Produce action plans which show how we will continue to embed equality and diversity in our work as a regulator and employer.
- b Build on our engagement with a diverse range of interest groups to inform our policies and activities.
- c Do more work to understand the impact of our policies and procedures on diverse groups of people.

Other areas

12 Other activities will also form part of our Equality Scheme framework. Some examples have been set out below:

- a Improve the quality of the diversity information that we collect from doctors, the public and our staff and use this information to inform and improve our services.
- b Become an employer of choice. For example, review options for work experience and outreach for groups currently under-represented in the workforce.
- c Build the capacity of our staff in understanding equality and diversity issues, for example, reviewing our training for staff and continuing to raise their awareness of equality and diversity.

APPENDIX TWO

GMC EQUALITY SCHEME CONSULTATION RESPONSE FORM

Section 1 - Our Themes

In the consultation document, we have identified several possible themes for our Equality Scheme.

Do you think the following themes will contribute to an effective framework for our Equality Scheme?

Theme	Yes	No	Don't know
Theme 1: Providing accessible information and services			
Theme 2: Helping doctors to provide high quality care			
Theme 3: Being a fair regulator			
Theme 4: Using our influence to create positive change			

Please use this box to tell us if there are other themes that you would like to see included in the Equality Scheme framework.

--

Section 2 - Our Outcomes

In the consultation document, we have set out some examples of what we want to achieve under each theme.

Do you agree with the following outcomes?

What we want to achieve	Yes	No	Don't know
Theme 1: Providing accessible information and services			
A complaints process which is fair, accessible and easy to understand.			
Publications and communications are accessible and reflect good practice.			
Registration / certification processes are accessible for doctors.			

Theme 2: Helping doctors to provide high quality care			
Improve the quality of care that people with disabilities receive from their doctors.			
Ensure doctors understand the standards and ethics for practising in the UK.			
Theme 3: Being a fair regulator			
Our policies, processes and procedures are fair, transparent and non-discriminatory.			
Understand the impact of our policies and processes on diverse groups of doctors, patients and service users.			
Enhance the understanding of doctors, patients and the public about our fitness to practise procedures.			
Theme 4: Using our influence to create positive change			
Our work on equality and diversity makes a difference and improves outcomes for diverse groups of people			
We raise awareness of potential barriers with our partners and other influential organisations to help to change things for the better			

Please use this box to tell us whether there are any further outcomes that we should consider.

--

Section 3 - Our Activities

In the consultation we list some examples of the activities that we might undertake.

	Yes	No	Don't know
Do you think that these activities will help the GMC to fulfil its legal obligations?			
Would you like to be involved in any of this work?			

Please use this box if you have any further comments on these activities.

--

Please use this box if you have any further comments on this consultation.

--

Section 4 Your Details

Your contact details

Please enter your contact details.

Name:	
Address:	
Email:	
Contact Tel:	

Please indicate with a tick(s) the work areas below for which you would like to be notified about future GMC consultations. (If you do not wish to be notified about any future GMC consultations, please leave this blank.)

Education	
Standards and ethics	
Fitness to Practise	
Registration	
Licensing and revalidation	

Your role

Are you responding to this consultation as an individual or on behalf of an organisation?
Please tick one only.

Individual (go to 'About you as an individual')	
Organisation (go to 'About your organisation')	

About you as an individual

To help ensure that our consultations are reflecting the views of the diverse community please fill in the information below. Although we will use this information in our analysis of the consultation response it will not be linked to your response.

Data Protection

The information you supply will be stored and processed by the GMC in accordance with the Data Protection Act 1998 and will be used to analyse the consultation responses and help us to consult more effectively in the future. Any reports published using this information will not contain any personally identifiable information. We may provide anonymised responses to the consultation to third parties for quality assurance or approved research projects on request.

Which of the following categories best describes you? Please tick one only.

Doctor	
Medical educator (teaching, delivering or administrating)	
Medical manager	
Medical researcher	
Medical student	
Member of the public	
Other healthcare professional	
Other (please give details)	

What is your country of residence? Please tick one only.

England	
Northern Ireland	
Scotland	
Wales	
Other – European Economic Area	
Other – rest of the world (please give details)	

What is your age? Please tick one only.

Under 24	
25-34	
35-44	
45-54	
55-64	
65+	

Are you (please tick one only):

Male	
Female	
Prefer not to say	

Is your gender identity the same as the gender you were born with? Please tick one only.

Yes	
No	
Prefer not to say	

Do you consider yourself to be a disabled person? Please tick one only

Yes	
No	
Prefer not to say	

Disability Discrimination

Under the Disability Discrimination Act 1995 a person is considered to have a disability if he/she has a physical or mental impairment which has a sustained and long-term adverse effect on his/her ability to carry out normal day to day activities. Examples include depression, dyslexia, diabetes, hearing impairment, visual impairment, epilepsy and arthritis. Since 2005, people with HIV, cancer and multiple sclerosis (MS) are covered by the DDA.

What is your ethnic origin? Please tick one only.

Asian or Asian British	<input checked="" type="checkbox"/>
Bangladeshi	<input type="checkbox"/>
Pakistan	<input type="checkbox"/>
Indian	<input type="checkbox"/>
Other Asian background (please specify)	<input type="checkbox"/>
British Mixed/Dual Heritage	<input checked="" type="checkbox"/>
White& Asian	<input type="checkbox"/>
White & Black African	<input type="checkbox"/>
White & Black Caribbean	<input type="checkbox"/>
Other Mixed background (please specify)	<input type="checkbox"/>
Black or Black British	<input checked="" type="checkbox"/>
Caribbean	<input type="checkbox"/>
African	<input type="checkbox"/>
Other Black background (please specify)	<input type="checkbox"/>
White or White British	<input checked="" type="checkbox"/>
White British	<input type="checkbox"/>
White Irish	<input type="checkbox"/>
Gypsy/ Roma	<input type="checkbox"/>
Irish Traveller	<input type="checkbox"/>
Other White background (please specify)	<input type="checkbox"/>
Chinese or Other Ethnic Group	<input checked="" type="checkbox"/>
Chinese	<input type="checkbox"/>
Any other ethnic background (please specify)	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>

What is your religion or belief? Please tick one only.

Buddhist	
Christian	
Hindu	
Jewish	
Muslim	
Sikh	
No Religion	
Prefer not to say	
Other belief (please specify)	

How would you define your sexual orientation? Please tick one only.

Bisexual	
Gay man	
Heterosexual/straight	
Lesbian/Gay woman	
Prefer not to say	
Other (please specify)	

About your organisation

Which of the following categories best describes your organisation? Please tick one only.

Body representing doctors	
Body representing patients or public	
Government department	
Independent healthcare provider	
Medical school (undergraduate)	
Postgraduate medical institution	
NHS / HSC organisation	
Regulatory body	
Other (please give details)	

In which country is your organisation based? Please tick one only.

UK wide	
England	
Northern Ireland	
Scotland	
Wales	
Other – European Economic Area	
Other – rest of the world (please give details)	

If your organisation's main purpose is to represent particular diverse group(s), or to work on particular area(s) of diversity, please indicate below using as many ticks as required.

Age	
Disability	
Ethnicity	
Gender	
Gender Identity	
Religion or belief	
Sexual orientation	
Socio economic	
None *	
Other (please specify)	

* i.e. it is not your organisation's main purpose to represent particular diverse groups, or to work on particular areas of diversity.

Please return your completed response form by 15 October 2010 to:

Elaine Bromberg
Equality and Diversity Manager
General Medical Council
350 Euston Road
London
NW1 3JN

ebromberg@gmc-uk.org

020 7189 5420

Textphone users. Please use the Text Relay Service: Dial Prefix **18001 + 0207 189 5420**

APPENDIX THREE

Online Consultation – Consultee Profile

Summary

Profile Responses

RESPONDING AS INDIVIDUAL	RESPONDING ON BEHALF OF AN ORGANISATION	NUMBER OF RESPONSES
36 (80%)	9 (20%)	45

CATEGORY OF RESPONDENT	
Doctor	21 (50%)
Representative of doctors	3 (7.1%)
Husband of patient	1 (2.4%)
Public/citizen	6 (14.2)
Medical manager	2 (4.8%)
Third sector	3 (7.1%)
Chaplain	1 (2.4%)
Medical educator	1 (2.4%)
Other health care professional	2 (4.8%)
Regulatory body	1 (2.4%)
Trade union/professional body (midwives)	1 (2.4%)
Total	42

COUNTRY OF RESIDENCE				
England	Northern Ireland	Scotland	Wales	NUMBER OF RESPONSES
31 (88.6%)	-	4 (11.4%)	-	35

AGE							
Under 25	25-34	35-44	45-54	55-64	Over 65	PNTS	NO
-	8 (24.2%)	13 (39.4%)	5 (15.2%)	5 (15.2%)	-	2 (6.1%)	33

GENDER			
FEMALE	MALE	PNTS	NUMBER OF RESPONSES
9 (25.7%)	24 (68.8%)	2 (5.7%)	35

GENDER IDENTITY SAME AS BORN WITH			
YES	NO	PNTS	NUMBER OF RESPONSES
33 (94.3%)	-	2 (5.7%)	35

DISABILITY			
YES	NO	PNTS	NUMBER OF RESPONSES
4 (11.4%)	29 (82.9%)	2 (5.7%)	35

ETHNICITY					
White British	Indian	Black Other	Any other	PNTS	NUMBER OF RESPONSES
9 (28.1%)	17 (53.1%)	1 (3.1%)	1 (3.1%)	4 (12.5%)	32

RELIGION OR BELIEF							
Hindu	Buddhist	Christian	Muslim	None	Sikh	PNTS	NUMBER OF RESPONSES
12 (34.3%)	1 (2.8%)	8 (22.8%)	3 (8.6%)	7 (20%)	1 (2.8%)	3 (8.6%)	35

SEXUAL ORIENTATION							
Lesbian	Gay	Bisexual	Metrosexual	Heterosexual	PNTS	NUMBER OF RESPONSES	
-	1 (3%)	1 (3%)	1 (3%)	28 (84.8%)	2 (6.1%)	33	

CATEGORY OF ORGANISATION							
NHS	Rep Drs	Rep patient	TU	Third sector	Post grad	Reg body	NUMBER OF RESPONSES
19 (54.3%)	6 (17.2%)	3 (8.6%)	1 (2.8%)	4 (11.4%)	1 (2.8%)	1 (2.8%)	35

BASE OF ORGANISATION							
England	N Ireland	Scotland	Wales	UK	Eng/Wales	NUMBER OF RESPONSES	
12 (32.4%)	-	4 (10.8%)	-	19 (51.4%)	2 (5.4%)	37	

EQUALITY GROUPS REPRESENTED							
All	Religion Belief	Age	Ethnicity	None	Gender	Disability	NUMBER OF RESPONSES
2 (7.4%)	1 (3.7%)	1 (3.7%)	4 (14.8%)	16 (59.3%)	1 (3.7%)	2 (7.4%)	27

N.B. PNTS – Prefer Not To Say

Online Responses

86 responses were received but 6 of these had no information that was useful to the consultation and so are not included in the analysis below

Will themes contribute to an effective framework?

Yes	No	Don't know	No of responses
Providing accessible information and services			
69 (90.8%)	2 (2.6%)	5 (6.6%)	76
Helping doctors provide high quality care			
64 (84.2%)	7 (9.2%)	5 (6.6%)	76
Being a fair regulator			
67 (88.1%)	5 (6.6%)	4 (5.3%)	76
Using influence to create positive change			
61 (81.3%)	6 (8%)	8 (10.7%)	75

Theme 1 – accessible information and services

Yes	No	Don't know	No of responses
Complaints process that is fair, accessible and easy to understand			
63 (88.7%)	4 (5.6%)	4 (5.6%)	71
Publications and communications are accessible and reflect good practice			
63 (88.7%)	3 (4.2%)	5 (7%)	71
Registration and certification processes are accessible for doctors			
58 (82.8%)	4 (5.7%)	8 (11.4%)	70

Theme 2 – Helping doctors to provide high quality care

Yes	No	Don't know	No of responses
Improve the quality of care people with disabilities receive			
59 (88%)	3 (4.5%)	5 (7.5%)	67
Ensure doctors understand the standards and ethics of UK practice			
64 (92.7%)	3 (4.3%)	2 (2.9%)	69

Theme 3 – Being a fair regulator

Yes	No	Don't know	No of responses
Policies, processes, procedures are fair, transparent and non-discriminatory			
46 (75.4%)	10 (16.4%)	5 (8.2%)	61
Understand the impact of policies, processes on diverse groups			
47 (77%)	7 (11.5%)	7 (11.5%)	61
Enhance the understanding of doctors, patients and the public about FTP			
44 (73.3%)	9 (15%)	7 (11.7%)	60

Theme 4 – using influence to create positive change

Yes	No	Don't know	No of responses
E and D work makes a difference and improves outcomes			
41 (67.2%)	14 (22.9%)	6 (9.8%)	61
Raise awareness of potential barriers with partners to change things			
44 (73.3%)	9 (15%)	7 (11.7%)	60

Will activities help the GMC to fulfil its legal obligations?

Yes	No	Don't know	No of responses
25 (46.3%)	6 (11.1%)	23 (42.6%)	54

Would you like to be involved in any of this work?

Yes	No	Don't know	No of responses
28 (51.8%)	11 (20.4%)	15 (27.8%)	54

APPENDIX FOUR

Interviews and Focus Group Contributors

Organisation	Location
Age Cymru	Wales
Ascend Scotland	Scotland
BME Carers	United Kingdom
British Medical Association	United Kingdom
Independent contributor	England/UK
Children's Law Centre	Northern Ireland
Children's Rights Alliance for England	England
Church of Ireland	Northern Ireland
Community Health Council	Wales
Cranhill Community Project	Scotland
Disability Action Northern Ireland	Northern Ireland
Dumfries and Galloway Coalition of Disabled People	Scotland
Equalities and Human Rights Coalition Wales	Wales
GIRES	England
Inclusion Scotland	Scotland
Interfaith Network UK	United Kingdom
Manchester Alliance for Community Care	England
Oxfam Cymru	Wales
MENCAP	United Kingdom
NHS Employers	England
People First	United Kingdom
Press for Change	England/UK
Rainbow Project	Northern Ireland
Royal College of Physicians	United Kingdom
Royal College of Radiologists	United Kingdom
RNID Cymru	Wales
ROTA	England/UK

Scottish Council on Deafness	Scotland
Scottish Independent Advocacy Alliance	Scotland
Scottish Women's Convention	Scotland
Stonewall	England/UK
Stonewall Cymru	Wales
The Gender Trust	England/UK
Women's Support Network	Northern Ireland

In addition three individual services users took part in the consultation

APPENDIX FIVE

Profile of Organisations attending interviews and focus group

Protected characteristic	Number
All protected characteristics	4
Age	3
Older Age	1
Children and Young People	2
Carers	2
Disability – includes a wide range of impairments, learning disabilities, mental health	5
Deaf or hearing impaired	4
Visually Impaired	1
Learning Disabilities or difficulties	4
Mental Health	2
Gender – specifically women	3
Race	3
Refugees and Asylum seekers	2
Religion and belief – specifically faith organisations	3
Lesbian, gay and bisexual	3
Socio-economic/ deprived communities	5
Transgender	2

N.B one organisation may represent more than one protected characteristic.