

Question: Do you agree or disagree with the proposed text on discriminatory behaviour for inclusion in our guidance?

GPhC proposed text

Discriminatory behaviour and attitudes undermine public confidence and trust in the pharmacy professions and can have an impact on the reputation of professionals. Our standards state that we expect professionals to recognise and value diversity, and respect cultural differences, making sure that every person is treated fairly whatever their values and beliefs. This is essential for professionals to provide safe care and maintain trust with their patients and colleagues.

All forms of discriminatory behaviour on the part of professionals towards patients, the public and colleagues are unacceptable in society. We take all concerns relating to this seriously. Discriminatory behaviour can include:

- abusive verbal comments, including hate speech, or offensive writing towards someone because of their protected characteristics such as their race, sex and gender, religion or sexuality*
- threatening or aggressive behaviour towards someone because of their race, sex and gender, religion, sexuality or other protected characteristics*
- comments on social media or public platforms about a particular group of people because of their protected characteristics*
- refusing a patient treatment based on the patient's protected characteristics*
- treating a patient less favourably because of a protected characteristic*
- treating a colleague less favourably because of their protected characteristics*

Discriminatory behaviour can happen in various settings including at a professional's place of work when interacting with patients or colleagues, in their personal life or in a wider social setting. The committee should consider the circumstances in which the behaviour took place. This is so it can decide if there are any wider implications in maintaining public confidence in the profession. The committee should also consider any cautions or convictions as a result of the professional's actions, and any implications this may have on their fitness to practise and the wider pharmacy profession.

When deciding on an outcome, the committee should balance all the relevant issues, including any aggravating and mitigating factors. Because of the serious nature of these concerns and the impact on public trust and confidence in the profession, the committee should consider outcomes at the upper end of the scale.

Table 1: examples of cases relating to discriminatory behaviour

Concern details	Expected outcome
<i>A conviction for racist and/or religious hate crime, or other racially or religiously aggravated offences</i>	<i>Removal would be the expected outcome</i>
<i>A superintendent pharmacist bullied and harassed a number of staff across a period of time and their behaviour had a significant impact on these colleagues</i>	<i>An outcome from the upper end of the scale would be expected</i>

The outcome of an employment tribunal found a pharmacy professional was discriminated against in the workplace by their employer. The employer, a pharmacy professional, was then referred to the GPhC about their actions in relation to the case

An outcome from the upper end of the scale, most likely removal, would be expected

A pharmacy professional makes a number of racially motivated comments on social media which are investigated by the police but do not result in any conviction

An outcome from the upper end of the scale would be expected

GMC response

Scale: Agree.

Response: Overall, we agree with the direction of the proposed text. We have provided some comments below which we hope will be helpful for you to consider should you wish to refine the text or develop it further.

In the opening paragraph you refer to several of the professional standards that are relevant to discrimination and say they are ‘essential for professionals to provide safe care and maintain trust with their patients and colleagues’. For consistency with how you’ve described the potential impact of discrimination elsewhere, you may want to explicitly refer to maintaining trust with patients, colleagues and ‘members of the public’ here too.

We agree that discrimination may be seen both inside and outside a professional’s working life and it is helpful to provide examples of how this type of behaviour may be exhibited.

The examples of discriminatory behaviour you’ve given in the proposed text all refer to ‘protected characteristics’. For clarity about what this term means, it may be useful to provide a link to the relevant legal framework and / or explain that in the UK there are nine protected characteristics set out in the Equality Act 2010. You may also want to consider distinguishing between direct and indirect discrimination

We note that in the following example you’ve listed some, but not all, of the specific protected characteristics: ‘threatening or aggressive behaviour towards someone because of their race, sex and gender, religion, sexuality or other protected characteristics’. The terminology used does not accurately reflect the words from the Equality Act 2010, for example ‘sexuality’ is described in the Act as ‘sexual orientation’. We also wondered if there was a reason for only listing some of the individual protected characteristics, as doing so could carry a risk of creating the impression of a hierarchy. Because of this, it may be better to only use the general reference to ‘protected characteristics’ as you have elsewhere. Alternatively, you may want to consider listing all nine characteristics using the wording from the Equality Act 2010 itself for accuracy.

We are currently considering discriminatory behaviour that may not relate to a protected characteristic as part of a review of our own guidance and wonder if you are giving any thought to that.

We agree as a general principle that some allegations against a professional represent such a significant departure from the standards expected that they will usually indicate a high level of seriousness. This is because the failure is an abuse of, or interference with an individual’s dignity,

and/or breaches the fundamental tenets of the profession to act with honesty, integrity and uphold the law.

We also agree that discriminatory behaviour relating to a protected characteristic is a case type that's likely to indicate a high level of seriousness. Our [Guidance for Case Examiners on making decisions at the end of the investigation stage](#) identifies 'unlawful discrimination in relation to a characteristic protected by law' as a category of case where there is a presumption of an issue of impaired fitness to practise (paragraph 24) and our [Sanctions guidance](#) identifies 'discrimination against patients, colleagues and other people' and 'discriminating in relation to characteristics protected by law', as being likely to lead a tribunal to consider taking more serious action (paragraphs 55 and 141).

Having considered your proposed text, we consider it may be appropriate to reflect, like with other types of behaviour, that discrimination can still exist on a sliding scale of seriousness. We suggest this could be achieved if the word 'usually' was inserted into the statement '...decision makers should usually consider outcomes at the end upper end of the scale.'

In the table giving examples of cases of discrimination and the expected outcome, you've included a scenario where there has been an employment tribunal finding made against a professional. Determinations from employment tribunal proceedings are not determinative proof of the facts in FtP proceedings and are not automatically admissible in the way that certificates of convictions are. Although decision makers in regulatory proceedings can consider the admissibility of evidence which was put before an employment tribunal and attach weight such weight as they see fit, we consider this type of scenario could potentially be complex and so there is a risk that directing decision makers toward removal may be disproportionate.

The proposed text is explicit in several places about how discriminatory behaviour impacts on public confidence in professionals, which is useful. To encourage decision makers to consider how the circumstances of a case may be capable of engaging each of the three limbs of the overarching objective, it may also be helpful to be explain how discriminatory behaviour impacts on patient safety and the maintenance of standards. For example, where discrimination has resulted in treatment not being provided, or a delay in treatment being provided, this may impact the physical, emotional and / or psychological wellbeing of a patient or member of the public which may affect how they access health services in the future. Where discrimination is towards colleagues, in addition to any harm caused to them, it may impact on patient safety by causing breakdowns in communication and / or in the collaborative working needed to deliver safe patient care.

Question: Do you agree or disagree with the proposed text on cultural factors in insight, remorse and testimonials for inclusion in the guidance?

GPhC proposed text

When deciding what action to take, decision makers must consider:

- *the nature of the concern*
- *whether the actions can be remediated, and*
- *if a professional can demonstrate insight.*

There may be some cases where a professional's conduct is so serious that it is not remediable. This means that even though the professional may provide evidence of insight and remediation, the

conduct is so serious that it is not appropriate to take this evidence into account when considering an outcome. Examples where this may occur include concerns involving discriminatory behaviour or sexual misconduct. This is because regulatory action is necessary to ensure public protection and maintain public confidence in pharmacy, and a professional's involvement in these matters can undermine this.

The committee should be aware that there may be cultural differences or a professional's personal circumstances, such as ill-health, that may affect the way an individual communicates and expresses themselves. This could affect, for example, how an apology, insight or expression of regret is framed and delivered. This is particularly the case for individuals who are communicating in a second language and may use elements of their first language to construct their sentences or statements. This could alter the intended meaning when spoken in their second language. Expressions of apology, and how an apology is communicated, can differ across cultures, and be affected by religion and beliefs. For example, in some cultures written apologies are not the norm.

There may also be differences in the way individuals use non-verbal cues to communicate. This will include, among other things, facial expressions, eye contact and gestures. For example, a professional with a sight impairment may have difficulty making eye contact with committee members. The committee should be aware of and sensitive to these issues when deciding how a professional frames their insight and remorse, and in judging their behaviour and attitude during the hearing.

Testimonials (or references) can have an important bearing on the outcome of a fitness to practise hearing and may be submitted as mitigation at a hearing. Committees should first consider whether these are genuine and can be relied upon. The committee should consider whether the authors of the testimonials were aware of the events leading to the hearing and what weight, if any, to give the testimonials.

The committee should be aware that in some circumstances, there may be cultural or other reasons why a professional may not want to ask for testimonials (or references). For example, sharing information about their investigation with family members or colleagues may affect their private lives, and their reputation with their family and community. The committee should bear this in mind and not make assumptions about why there is an absence of this type of evidence. Equally the committee should not speculate as to what may have been said had any references or testimonials been requested.

As with other mitigating or aggravating factors, any references and testimonials will need to be weighed appropriately against the nature of the facts found proved and be considered at the appropriate stage of the process. The committee will need to consider the appropriate stage for them to take account of personal mitigation and testimonials.

Testimonials prepared before a hearing should be considered in the light of the factual findings made at the hearing. Testimonials or other evidence which confirms the steps taken by the professional to remedy the behaviour which led to the hearing (for example from professional colleagues) and evidence of how the professional currently practices may be relevant when the committee is considering the issue of impairment. This evidence should not be left to the outcome stage.

GMC response

Scale: Disagree

Response: We have selected the response 'disagree' because on balance, the areas of text that we disagree with outweigh those we agree with. Further explanation is provided below.

Through regulatory reform, the Department for Health and Social Care intend to establish a category of cases in which a professional's behaviour is regarded as being so serious that it should result in them being automatically removed from their professional register, without the regulator needing to consider facts and impairment first. In the absence of that overarching framework, we don't agree that regulators should say that certain behaviour is not remediable and that it is not appropriate to take evidence of insight and remediation into account in specific cases. We don't consider that such a position is consistent with current case law precedent.

However, we do consider that regulators can appropriately give the direction that in cases where the departure from the standards expected indicates a high level of seriousness, factors which may otherwise lessen the risk the professional poses to public protection, such as the medical professional's personal context and their response to the concern, will usually carry less weight because these types of allegations can be difficult to remediate and so the decision maker's view should be weighted to reflect this.

We agree with the proposed text explaining how cultural differences or a professional's personal circumstances, such as ill-health, may affect the way an individual communicates and expresses themselves. However, when referring to 'ill-health' it may help to be more specific and use up-to-date terminology, such as 'the impact of a health condition or disability'.

To further support fair decision making it may be helpful to expand the text to include the following points:

- Decision makers should be aware of the impact of some disabilities, such as neurodiversity and the barriers this can create to cognition, social communication and the perception of an individual's behaviour.
- An individual may think, feel or behave differently because of their cultural background. To support fair decision making, decision makers should set aside any assumptions they have about an individual's culture and the impact it may have on that individual's behaviour, performance, or engagement with the fitness to practise process. Their decision should be informed by any relevant information available about the individual's cultural background and the impact it has had in the circumstances.
- Decision makers should be aware of the assumptions their own culture shapes about others and critically review the personal and professional biases that may impact on the decisions they make. It may also be helpful to provide some examples of biases that are relevant in the context of their decision making, such as affinity bias, anchoring bias etc.
- [Speaking up: Accents and social mobility](#) references accent bias and states that 25% of professionals reported being mocked, criticised or singled out in work situations because of their accent. You may want to consider expanding the text to ask panels to consider differences in accents as well as cultural expressions.

We agree with some of the points made about testimonials, such as the reasons why they may not be provided and the importance of not making an adverse inference where they are not available, however we think you could be more specific in terms of their relevance at different stages of the FtP process. For example, testimonials that provide evidence about the professional's insight and remediation may be relevant to the decision on impairment, whereas references and testimonials that simply support the professional and / or provide a view on their character are only relevant when considering sanction.

Although the weight to be given to evidence provided in references and testimonials is a matter for the decision maker, our [Sanctions guidance](#) states that a tribunal is likely to be able to place greater emphasis on testimonials that have been verified (paragraph 35). It's also our view that in most cases, particularly in those where the professional's behaviour or poor performance indicates a high level of seriousness, the need to protect the public will outweigh any relevant evidence about the medical professional's character.

Do you think our proposals will have a positive or negative impact on individuals or groups who share any of the protected characteristics?

We want to understand whether our proposals may have a positive or negative impact on individuals or groups sharing any of the protected characteristics in the Equality Act 2010.

The protected characteristics are:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race/ethnicity
- religion or belief
- sex
- sexual orientation

GMC response

We think your proposals could potentially impact all groups covered by the Equality Act 2010 and have taken a look at the [Survey of registered pharmacy professionals 2019 to inform our response](#). However, without sight of your equality impact assessment, which would include data on the specific breakdown of the pharmaceutical profession and / or patients and complainants involved in your FtP processes, we are only able to make some limited observations about some of the impacts.

Overall, we consider it's likely that being clear about your position on discrimination and setting this out should have a positive impact on professionals and patients with protected characteristics. But it may be helpful to illustrate the guidance with some more specific examples to ensure an understanding of where discrimination could apply across the protected characteristics.

We also consider it's likely that being clear about your position on cultural competency and setting this out should have a positive impact on professionals with protected characteristics.

Whilst the focus of the guidance seems to be on professionals, decision makers also need to be aware of the diversity of patients and members of the public raising concerns, their vulnerability, and the considerations that need to be made to enable them to engage with the fitness to practise process. We are not clear on how you are proposing to address this point.

Pregnancy and maternity - Potential for positive impact

Clearly outlining that discrimination is a regulatory issue should have a positive impact and encourage colleagues to treat pharmacy professionals who are pregnant, or those on maternity

leave, fairly and with respect. Equally, it should provide reassurance to pregnant patients seeking pharmacy services, that they will be treated fairly if they raise a complaint of discrimination.

Age - Potential for negative impact

It may be helpful to provide some additional guidance on age. This is because it could create an impression that making clinical decision based on age will always amount to discrimination, whereas at times, factors including age can inform the basis of a clinical decision and might be justified.

Gender reassignment - Potential for negative impact

There may be some nuances in relation to prescribing / dispensing medication e.g. hormone blockers for children and young people (see [Cass, 2022](#)) which may need to be bought out as examples in the guidance. In addition, and more broadly, the importance of not discriminating against trans patients seeking pharmacy services and ensuring they do not receive a lower standard of care could be made explicit.

Race - Potential for positive impact

With reference to the [Survey of registered pharmacy professionals 2019](#), those not trained in the UK or new to the UK may lack the same level of understanding of the cultural expectations within the UK healthcare system to be able to demonstrate insight in the same way as those trained in the UK. Asking decision makers to be cognisant of this should benefit professionals falling within this group and therefore have a positive impact.

Disability - Potential for positive impact

Disability is wide ranging and there are many groups that might communicate and understand information in different ways, for example, those with autism, those with an acquired brain injury or people with ADHD. As a result, asking panels to be aware that a professional's personal circumstances may affect the way they communicate and express themselves should positively impact those professionals when they provide evidence. However, you may wish to reflect in the guidance that it is not just about how individuals communicate, but also the support they need to understand the information that is communicated to them during the fitness to practise process.