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IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
THE ADMINISTRATIVE COURT

Royal Courts of Justice
Strand
London WC2A 2LL

Thursday, 10 April 2014

B e f o r e:

MR JUSTICE MITTING

Between:
THE QUEEN ON THE APPLICATION OF BAPIO ACTION LTD
Claimant

v

ROYAL COLLEGE OF GENERAL PRACTITIONERS
First Defendant

GENERAL MEDICAL COUNCIL
Second Defendant

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(Official Shorthand Writers to the Court)

Ms K Monaghan QC and Ms S Hannett (instructed by Linder Myers) appeared on behalf of the **Claimant**
Mr P Oldham QC (instructed by Clyde & Co) appeared on behalf of the **First Defendant**
Mr J Bowers QC and Mr I Hare (instructed by GMC) appeared on behalf of the **Second Defendant**

J U D G M E N T
(Approved)

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1. MR JUSTICE MITTING: In this judgment I will use only two acronyms: "GMC" for General Medical Council, because it is in general use, and "BME" for Black and Minority Ethnic, an imprecise and shifting definition of categories of people perceived to be at a disadvantage within Western society. Any reference to "he" includes reference to "she".

2. Before a person can practise unsupervised as a general practitioner in the United Kingdom, he must satisfy a series of educational and vocational training requirements, typically achieved over a period of ten years:

1) a first degree in medicine and surgery or equivalent, awarded by a UK or foreign medical school, typically requiring five years' study;
2) a two-year Foundation Programme in the United Kingdom, typically made up of six four-month placements in different specialities in a hospital or general practice setting. At the end of each placement and year a doctor's performance is assessed by those who have supervised him;
3) a doctor with a first degree from a foreign medical school, not taught in English, must achieve level 7 of 9 on an International English Language Test, a widely used test of general competence in English, and pass a professional and linguistic assessment intended to demonstrate that he has achieved the level of a UK graduate who has completed Year 1 of the Foundation Programme. He must also have undertaken at least 24 months of experience in educationally-approved posts in the United Kingdom or overseas since graduating;
4) both categories of doctor must then have a computer-based assessment of their competence and skills as doctor. The standard is that of a doctor who has successfully completed Foundation Year 2. The pass rate is just over 50 per cent. The doctor is then allocated to a Deanery of his choice in descending order of success in the assessment;
5) the doctor will then undergo a three-year training programme, partly in hospital and partly in general practice, under the supervision of one of the Deaneries;
6) towards the end of the three-year programme the doctor must submit to a three-part assessment: 1) a work place assessment; in other words, assessments by those who have supervised his work during the three year programme; 2) a computer marked applied knowledge test; 3) a Clinical Skills Assessment. If successful in all three, the doctor will be awarded a Certificate of Completion of Training by the Royal College of General Practitioners ("the Royal College").

3. The Clinical Skills Assessment is designed to assess the doctor's skills in three respects: 1) gathering information from patients; 2) developing a diagnosis; 3) communicating with the patient. The assessment takes half a day and is based on role play. The part of the patient is played by a professional role player. 13 cases are selected from a regularly refreshed database of 696 cases. The doctor is given ten minutes in which to examine the patient, reach a diagnosis and explain it to the patient. The process is intended to mimic a real consultation. It is witnessed by an examiner who is an experienced practising or recently retired general practitioner. The examiner and "patient" are the same for each group or "diet" of doctors to be assessed. Marks are awarded out of four for each of the three clinical skills tested: 0 is a clear fail, 1 is a fail, 2 is a pass and 3 is a clear pass. The doctor can therefore score a maximum of 9 per case and 117 overall.

4. The assessment was devised and is set and supervised and refreshed by the Royal College. The clinical skills assessment was approved by the Postgraduate Medical Education and Training Board, now subsumed within the GMC, in 2007.

5. The method of determining those who had passed and failed was changed in 2010. Before 2010 a doctor who achieved a pass, in other words a 2, in nine out of 12 cases (the 13th was an unmarked pilot case) passed, however badly he had done on the remaining three cases. A doctor who failed to achieve nine passes failed, however well he had done on those that he had passed. This was thought to be potentially unfair to the latter and too generous to the former. It also failed to allow for relative difficulty in the cases upon which a doctor was assessed. On a day of difficult cases a doctor might, unfairly, do less well than another doctor would do on a day of easy cases.

6. The replacement system required examiners to answer, but not mark, how a doctor had performed in the case examined: Pass, borderline or fail. The scores of all those assessed as "borderline" were then collated and a mean score determined. After adjusting by a margin of 1.64, the mean score was then the pass mark for that "diet". The mean score has proved by experience to be about 73 out of 117. Four attempts, plus, exceptionally, a fifth, are allowed.

7. All but a handful, at most three per cent, of the doctors who submit to the assessment eventually succeed. Figures collated by the Royal College show that between October 2007 and May 2012, 133 out of 11,862 candidates who had undertaken the Clinical Skills Assessment more than four times still failed. Of that 133, 120 were foreign graduates. That figure may not, however, include all of the candidates who, in one way or another, fail the assessment. Some will give up all together. Bapio suggests that the true figure may be as high as 300, hence my outline estimate of the number of those who ultimately fail as up to three per cent.

8. There is a marked difference in the pass rate at first attempt of doctors who have a first degree from a UK medical school and those with a first degree from a foreign medical school and between different groups of doctors, categorised by race in each category. The difference is illustrated by the figures for the year August 2012 to July 2013. There are minor anomalies in the figures supplied which do not materially affect the overall pattern. 87.7 per cent of UK graduates passed at first attempt, but only 52.1 per cent of non-UK graduates. Within the category of UK graduates, 93.5 of those describing themselves as "white" passed but only 76.4 and 72.7 per cent of those describing themselves as "South Asian" or "black" respectively. Within the category of non-UK graduates, 62 per cent of those describing themselves as "white" passed at first attempt but only 49.6 and 51.6 per cent of those describing themselves as "South Asian" or "black" respectively.

9. The Claimant's case is that the Royal College as assessor and the GMC as regulator have failed to fulfil the public sector equality duty imposed on them by section 149 of the Equality Act 2010 and that the differences in outcome described are, in whole or in part, the result of that failure and establish against the Royal College alone that it has discriminated, directly or indirectly, against South Asian and BME doctors. Both the

Royal College and the GMC assert that they have, in fact or in substance, fulfilled their public sector equality duty and, in the case of the Royal College, it denies that it has discriminated against South Asian and BME doctors.

10. The first, and by now uncontroversial, issue is whether or not the public sector equality duty applies to the Royal College and the GMC. The GMC has always admitted that it does and the Royal College is prepared, for the purposes of these proceedings, to accept that it does. Both concessions are right. The GMC is a public authority, listed as such in schedule 19 to the 2010 Act. The Royal College exercises public functions. Paragraph 2(j) of the Royal Charter granted to it in 1972 empowers it:

> "To conduct examinations and award postgraduate diplomas or other certificates of proficiency or standard in general medical practice . . . "

11. The award of a Certificate of Completion of Training to a doctor who successfully completes the three-part assessment at the end of his three years' vocational training permits him to practise as a general practitioner in the United Kingdom. That is a matter of public importance and not just of private importance for the doctor. The health of all or almost all members of the public is dependent to some extent on the conscientious and skillful performance by general practitioners of their duties. Consequently, the exercise of the power to determine who should be authorised to perform those duties is a matter which affects the public as a whole. It is clearly a function of a public nature and would be so categorised for the purpose of section 6(3)(b) of the Human Rights Act 1998. Accordingly, the public sector equality duty applies to the Royal College (see 150(5) of the 2010 Act.)

12. The public sector equality duty is set out in section 149(1):

> "(1) A public authority must, in the exercise of its functions, have due regard to the need to—
>
> (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
>
> (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
>
> (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it."

13. Is not only public authorities as such who are subject to the public sector equality duty. Subsection (2) provides:

> "A person who is not a public authority but who exercises public functions must, in the exercise of those functions, have due regard to the matters mentioned in subsection (1)."

14. The scope of the public sector equality duty imposed on a person who is not a public authority is, however, limited by those words. It is only, and I emphasise, "in the exercise of those functions", ie public functions, that the duty is imposed. As a matter of language, that limits the duty to the functions which the person who is not a public authority exercises, not those which it could exercise if it chose to do so. Paragraph 2(d) of the Royal College's charter requires it:

> "To undertake or assist others in undertaking training courses or other educational activities designed to enhance the medical knowledge and skill of general practitioners."

15. If, which I doubt, that paragraph empowers the Royal College to train doctors who wish to be general practitioners rather than those who have already become general practitioners, it does not, in fact, do so. Training of aspiring general practitioners is left to the Deaneries.

16. Ms Monaghan submits that the public sector equality duty might require the Royal College to establish training courses itself, to remedy perceived shortcomings in performance on the part of South Asian and BME doctors of the kind apparently identified by the Clinical Skills Assessment. I do not agree. The public sector equality duty cannot require the Royal College to consider exercising public functions which it has chosen not to exercise, or even to require it to consider exercising those functions.

17. A narrower submission is, however, justified. The Royal College's charter empowers it:

> "To encourage persons of ability to enter the medical profession and become general medical practitioners." (Paragraph 2(i)).

18. And:

> "To do all such other things as are incidental or conducive to the attainment of the object of the College." (Paragraph 2(p)).

19. The object defined at the start of paragraph 2 is:

> " . . . to encourage, foster and maintain the highest possible standards in general medical practice and for that purpose to take or join with others in taking any steps consistent with the charitable nature of that object which may assist towards the same."

20. Thus the Royal College is empowered to encourage the Deaneries to address the fact of underperformance by South Asian and BME candidates in the Clinical Skills Assessment by, for example, providing training to familiarise and equip them to deal with the assessment or to provide remedial training for those who have failed at first attempt. Dr Rendel, the Royal College's chief examiner who has provided lengthy witness statements in support of its case, can be encouraged to give the presentations to candidates to help them succeed, as she has done already (see paragraph 260 of her first

witness statement.) All of this activity is closely connected to the public functions which the Royal College is, in fact, exercising.

21. Accordingly, in my judgment, it is well within the scope of the public functions that it exercises for it to consider taking steps such as those I have identified. If the Royal College were not to consider taking steps such as those, it might well be that it would not, as of now and in the future, discharge its duty under section 149.

22. Such measures have, however, not been the target of this claim. Its target is the Clinical Skills Assessment itself. A declaration is sought that it is unlawful and the focus of the Claimant's pleaded concerns has been the nature and performance of the assessment. There it may be on weaker ground. There have been numerous investigations (about 18 at the last count) into the assessment by a medical academics and statisticians. In recent years notable reports include: 29 December 2010, a report by Katherine Woolf and others; May 2011, a review by Birmingham University; February 2012, one of several reports by Richard Wakeford of the University of Cambridge; 22 June 2013, a review by Denney, Freeman and Wakeford; 18 September 2013, a report commissioned by the GMC by Professors Esmail and Roberts and, later on in 2013, a report by Professor Norcini. It is not necessary to refer extensively to these reports. All that I need do for the present purposes is to summarise their conclusions:

1) there is a persisting difference in the outcomes of the clinical assessments between:
a) doctors who are UK graduates and those who are foreign graduates;
b) doctors who are UK graduates who are white and those who are South Asian or BME;
c) doctors who are foreign graduates who are white and those who are South Asian or BME;
2) the difference reflects similar experience in other tests conducted by the Royal College, the Applied Knowledge Test, and by other examiners, for example the Professional and Linguistic Assessment and by examiners in other medical disciplines, for example, psychiatry;
3) there is an unavoidable risk of subconscious bias on the part of role players or, more significantly, examiners in a role play-based test. In one instance (in Denney et al), a small but significant bias was measured. BME examiners rated BME candidates 2.2 per cent higher than did their white colleagues;
4) a significant part of the difference between UK graduates and foreign graduates can be put down to different standards of education and cultural experience in the countries in which they graduated. In particular, foreign graduates may lack familiarity with the approach expected by patients of general practitioners in the United Kingdom because of the nature of their training and the nature of medical practice in the country in which they trained.

23. In addition, Professors Esmail and Roberts have concluded that the possibility of subconscious racial bias on the part of examiners may also play a part in the difference in outcome. So, too, may other factors identified by Dr Rendel: In the case of foreign graduates, a different age profile and the possible relative lack of rigour of the Professional and Linguistic Assessment; in the case of all graduates, differences in the quality of training under different Deaneries leading to different success rates. For example, the London Deanery has a first time pass rate of 82 per cent, the East

Midlands Deanery a first time pass rate of 57 per cent. None of these factors are under the direct control of the Royal College.

24. In summary, the extensive research undertaken so far has identified the problem of differential outcomes which are only partly explicable by known factors and produced tentative suggestions for making alterations: within the competence of the Royal College, the encouragement of and cooperation with the Deaneries to educate candidates in the requirements of the Clinical Skills Assessment and an effort to secure a more representative profile of examiner. I would be surprised if the Royal College had not itself reached the conclusion that steps along those lines should now be taken and, if not, that the GMC, as its regulator, would not insist that they were taken.

25. Ms Monaghan's basic submission is that the Royal College should have embarked on those steps well before these proceedings were issued and that its failure to do so can ultimately be traced to a failure to fulfil its public sector equality duty in the systemic way required by the case law. She points, correctly, to the absence of any minute of a meeting of the Council of the Royal College before 15 June 2013, which refers to the commissioning of an Equalities Impact Assessment in respect of new policies and major decisions and to the denial, not now pursued, that the Royal College does exercise public functions and so is subject to the public sector equality duty. In those circumstances, she asks rhetorically, how can the Royal College have had due regard to its duties under section 149? She relies on by now fairly settled case law, beginning with R (Brown) v Secretary of State for Work and Pensions [2009] PTSR 1506, in which at paragraph 90 Aikens LJ said the following:

> "90. Subject to these qualifications, how, in practice, does the public authority fulfil its duty to have 'due regard' to the identified goals that are set out in section 49A(1) of the 1995 Act? An examination of the cases to which we were referred suggests that the following general principles can be tentatively put forward. First, those in the public authority who have to take decisions that do or might affect disabled people must be made aware of their duty to have 'due regard' to the identified goals . . . thus an incomplete or erroneous appreciation of the duties will mean that 'due regard' has not been given to them . . . .
>
> 91. Secondly, the 'due regard' duty must be fulfilled before and at the time that a particular policy that will or might affect disabled people is being considered by the public authority in question. It involves a conscious approach and state of mind."

26. In R (Hurley and Moore) v Secretary of State for Business Innovation and Skills [2012] HRLR 13 at 374, Elias LJ at paragraph 78 observed that:

> "The concept of 'due regard' requires the court to ensure that there has been a proper and conscientious focus on the statutory criteria, but if that is done, the court cannot interfere with the decision simply because it would have given greater weight to the equality implications than did the decision maker."

27. Finally, in R (Bailey) v London Borough of Brent Council [2011] EWCA Civ 1586 at paragraphs 73 to 75, Pill LJ observed:

> "73. In Harris, the council's stance was that section 71 considerations were effectively built into the decision making process because the development brief for the area and the relevant planning follows themselves reflected section 71 considerations. That submission was rejected by the court.
>
> 74. What was underlined in Harris was the need to analyse the material before the council in the context of the duty . . . which in this case is the duty to have due regard to the need to eliminate discrimination . . . .
>
> 75. I confirm that approach. When preparing policies and making decisions, decision makers must always keep in mind their duties under the 2010 Act."

28. Mr Oldham QC for the Royal College submits that substantial compliance with the duty suffices and that there is no need to prove a documentary trail, including an Equality Impact Assessment, to demonstrate compliance. He relies on Elias LJ's observations in Hurley at paragraph 74:

> "Similarly, there is no obligation in law to provide an equality impact assessment, although as Aikens LJ pointed out in R (Brown) . . . :
>
> > 'proper record keeping encourages transparency and will discipline those carrying out the relevant function to undertake their . . . duties conscientiously. If records are not kept it may make it more difficult, evidentially, for a public authority to persuade a court that it has fulfilled a statutory duty'."

29. All cases up to now have been concerned with the need for a public authority to apply its mind to the section 149 duty when proposing to take a decision which will have an impact on the users of existing services provided by the authority, for example a library, or of the financial terms on which people can make use of them, for example student fees. This case is different. It concerns what needs to be done to address a long-established state of affairs. I do not accept Ms Monaghan's submission, faintly made, that a duty to conduct a formal assessment of the differential impact of the Clinical Skills Assessment arose annually because the assessment was approved annually. I am dealing in reality, as is the Royal College, with a continuing method of assessment that, apart from a change in the method of marking, has remained in place for the last seven years. Nor do I accept Mr Oldham's proposition that the duty only arises when major change is contemplated. The duty is to have regard to the need to eliminate discrimination and advance equality of opportunity in the exercise of public functions, whether or not it is contemplated that there will be a change in the manner in which those functions are exercised. If there are grounds to believe that the manner in

which public functions is being exercised is not fulfilling the statutory goals, then due regard must be had to exercising them in a manner which does. I consider, therefore, and hold that the Royal College was and remains under a continuing duty to have regard to the need to eliminate discrimination and advance equality of opportunity in the exercise of its public functions of granting Certificates of Completion of Training and in setting and administering assessments which lead to the grant of that certificate and that it can only discharge that duty by conscientiously applying its mind to that need.

30. However, I accept Mr Oldham's submission that no formal Equality Impact Assessment was required or is now required. It is sufficient that the Royal College has addressed its mind to the need by commissioning and considering the many expert reports, plus that commissioned by the GMC, which it has done over the years.

31. In the case of a long-standing problem, such as that which exists here, that may not, however, be enough. Section 149 does not permit a person exercising public functions to identify the need to eliminate discrimination in one of the public functions it exercises and then do nothing about it. If it acted thus it would not be "having regard" to the need to eliminate discrimination in the exercise of its public function, it would be disregarding a specific need which it had itself identified. In many, but I think not in all cases, it might also be infringing section 19 if it acted thus.

32. On the facts of this case, the Royal College has now identified the respect in which, in the discharge of its public functions, it needs to act to eliminate discrimination and has identified some of the means by which that need might be addressed and fulfilled. The time at which it should act upon the information which it has gathered and analysed has either arrived or will do so very soon. If it does not act and its failure to act is the subject of a further challenge, it may well be held to be in breach of its duty under section 149 for that reason alone. As of now, I am not satisfied that it is in breach of its duties under section 149 or was at the time when this claim form was issued.

33. I turn then to the claims of direct and indirect discrimination under section 13 and 19 of the 2010 Act. Ms Monaghan recognises the difficulty of establishing direct discrimination when there is no individual claimant discriminated against and no person who has treated that person less favourably than he would treat others. In the language of section 13 there is no "A" or "B". Mr Oldham submits that without the participation of such individuals in the events which give rise to the claim, a claim of direct discrimination cannot succeed in principle. I would not go that far. A local authority which refused to employ black people or women could properly be the subject of a direct discrimination claim brought by the Equality and Human Rights Commission without the need to identify any individual black person or woman who had been refused employment. But in a case such as this which depends upon the performance of individuals in assessments examined by other individuals, I do not see how a claim of direct discrimination can be evaluated or substantiated. The statistical differences which exist do not of themselves establish direct discrimination, or transfer to the Royal College the burden of disproving discrimination under section 136. What they do, but all that they do, is to demonstrate that there is a difference of outcome. They do not establish the reason or reasons for the difference, still less that it is because the Royal

College, or individuals for whose actions the Royal College is responsible, are subjecting doctors who fail the assessment to less favourable treatment on a prohibited ground. I am satisfied that the direct discrimination claim does not get off the ground.

34. The same arguments are advanced in relation to indirect discrimination. Section 19 provides:

> "(1) A person (A) discriminates against another (B) if A applies to B a provision, criterion or practice which is discriminatory in relation to a relevant protected characteristic of B's.
>
> (2) For the purposes of subsection (1), a provision, criterion or practice is discriminatory in relation to a relevant protected characteristic of B's if—
>
> (a) A applies, or would apply, it to persons with whom B does not share the characteristic,
>
> (b) it puts, or would put, persons with whom B shares the characteristic at a particular disadvantage when compared with persons with whom B does not share it,
>
> (c) it puts, or would put, B at that disadvantage, and
>
> (d) A cannot show it to be a proportionate means of achieving a legitimate aim."

35. The provision criterion or practice identified by the Claimant is the requirement to undergo a Clinical Skills Assessment. Ms Monaghan submits that it puts South Asian and BME doctors at a disadvantage when compared with their white colleagues and that the Royal College cannot show it to be a proportionate means of achieving a legitimate aim.

36. A number of preliminary questions arise. Mr Oldham submits that South Asians and BMEs are not racial groups. I do not accept that submission as it stands. Section 9(4) provides that:

> "The fact that a racial group comprises two or more distinct racial groups does not prevent it from constituting a particular racial group."

37. One person can belong to two or more racial groups, for example a Sikh of Indian nationality, but so too can two people of different nationality, for example Pakistanis and Indians. A hotel keeper who excludes Asians from his hotel would be discriminating against them on grounds of race, even though individual Asians might be Pakistanis, Indians or Chinese. The group "Asians" would be a group comprising two or more distinct racial groups of people of different nationality and ethnicity.

38. What that example shows is that a racial group may be identifiable by reason of the fact that it is so categorised by the person discriminating. I am satisfied that "South

Asians" are a racial group comprising people of Pakistani, Indian, Nepalese and Sri Lankan nationality or ancestry. I doubt that BMEs can so categorised. Ms Monaghan submits that they can be because the Royal College categorises them as a group, but it does so not with a view to discriminating against them or a dealing with them in a manner different from that of other racial groups, but simply for statistical purposes. To establish a claim under section 19, it would probably be necessary to break down BMEs into component groups. That, however, is an academic issue, given that the section 9 claim has to be considered in relation to South Asians and because it would no doubt be possible to breakdown BMEs into component groups without undue difficulty.

39. It is rightly common ground that requiring would-be general practitioners to submit to a Clinical Skills Assessment is a provision, criterion or practice and that if it puts South Asian UK graduates at a disadvantage by comparison with their white UK graduate colleagues and South Asian foreign graduates at a disadvantage when compared with white foreign graduates, it is discriminatory and that it is for the Royal College to show that it is a proportionate means of achieving a legitimate aim to discriminate between them in the manner which has occurred.

40. I am satisfied that the Clinical Skills Assessment does put South Asians of both categories at a disadvantage when compared with their white colleagues in the same category. Can the Royal College show that the assessments are a proportionate means of achieving a legitimate aim? Two pieces of evidence establish beyond argument what the legitimate aim is. I take the first from the witness statement of Dr Rendel and her citation from a paper produced by the Royal College in January 2011.

> "The MRGCP [an acronym for the three assessments to which I have referred] is a licensing examination which is by definition 'high stakes' in that those who pass will be licensed to practise medicines in an unsupervised capacity. Patient safety is therefore paramount and given that assessment is an imperfect science, the treatment of the measurable error must act in favour of patients rather than doctors. Specifically, we must be more confident that doctors who pass are safe to practise than that doctors who fail are unsafe. This aim is achieved not by one examination component in isolation, but by all three components of the MRCGP acting in a mutually complementary and supportive capacity, much like the three legs of a stool."

41. In their report Professors Esmail and Roberts describe the assessment as follows:

> "The CSA is not a culturally neutral examination and nor it is intended to be. It is not and nor should it be just a clinical exam testing clinical knowledge in a very narrow sense. It is designed to ensure that doctors are safe to practise in UK general practice. The cultural norms of what is expected in a consultation will vary from country to country. So for example, a British graduate will have difficulty in practising in a general practice setting in France or India until they become acculturated to that system of care. British graduates have

> much greater exposure, both personally and through their training, to general practice when compared to the majority of IMG who graduate from health systems which are not as dominated by primary care as the NHS. Most medical schools in the UK now have well developed programmes for communication skills training, reflective practice and direct exposure of students to General Practice as a discipline."

["IMG" are International Medical Graduates, those to whom I have referred as "foreign graduates".]

42. I am also satisfied that the Clinical Skills Assessment is a proportionate means of achieving that legitimate aim. It is necessary to test three of the skills required of a general practitioner: 1) gathering information; 2) arriving at a diagnosis; 3) communicating with the patient. No better means of testing those skills has yet been devised than the Clinical Skills Assessment. The method is in common use across the civilised world, unsettling and expensive though it may be for those who fail the first time at a cost of £1,600. The eventual failure rate is very small.

43. The assessment serves the legitimate purpose of protecting patient safety by means that are, in principle, acceptable and do so at a human cost which is tolerable for those who ultimately succeed. There is no basis for contending that the small number who fail ultimately do so for any reason apart from their own shortcomings as prospective general practitioners.

44. Ms Monaghan submits that section 19 imposes on the Royal College the duty to take positive steps to reduce discrimination and that, in the absence of such steps, the means of achieving the legitimate aim should not be deemed proportionate. I do not agree. The fact that it is possible to improve on the means of achieving an aim does not mean that before improvement occurs the means are not proportionate. Section 19 does not demand perfection. What must be judged is the balance between disadvantage, aim and means at the time when the provision, criterion or practice is in place and is scrutinised.

45. By that standard, I am satisfied that the Clinical Skills Assessment is a proportionate means of achieving the legitimate aim identified. For those reasons, the claim against the Royal College must be dismissed.