Provisional Enquiries Guidance (Rule 4(4))

Introduction
1. This guidance is supplementary to the Guidance on categorising Stream 1, Notify RO and Notify Employer and Allocating cases to the National Investigation Team and the Regional Investigation Teams. It is intended to support assistant registrars (ARs) in deciding whether further enquiries should be made under Rule 4(4), clarifying the situations in which it is appropriate to make further enquiries and the types of information that can be obtained.

2. Our primary function as a regulator is to protect patients and public confidence in doctors. We do this by assessing the risk that is posed to the public by a doctor’s impaired fitness to practise. Our response to this risk must be proportionate and targeted.

3. Making further enquiries under Rule 4(4) can assist us to respond quicker and more proportionately to accurately assess risk in some cases, avoiding unnecessary investigation, and enabling us to focus on those cases that require full investigation.

Principles
4. Rule 4(4) provides an explicit power for the registrar (delegated to assistant registrars) to make further enquiries before making a decision at triage. The AR can:

   ‘…carry out any investigations as in his opinion are appropriate to the consideration of:

   a whether or not the allegation falls within section 35C(2) of the Act;

   b the practitioner’s fitness to practise; or

   c the matters outlined within paragraph 5 …[Rule 4(5) the five-year rule].’

5. Subject to the limitations referred to below at paragraph 12, this guidance provides for the AR to make further enquiries in three situations. These are where:

   a the allegation itself is unclear;
b it is unclear whether the allegation is serious enough to raise a question of impaired fitness to practice; or

c the allegation, on the face of it, is serious but the evidence may be unlikely to support a finding of impairment and further information is needed to clarify whether the allegation is capable of raising a question of impaired fitness to practise.

6 In relation to (a) above (i.e. the allegation itself is unclear) the AR must make sufficient reasonable enquiries to enable them to make a decision. Examples of clarification will include identifying relevant doctors, obtaining documents missing from the information received to date and/or clarification of places and dates from a complainant or referrer.

7 In relation to (b) above many allegations falling within this category are likely to be performance or health related. The AR can make enquiries under Rule 4(4) to clarify whether concerns raised about a doctor’s performance would require us to conduct an investigation (because they raise a question about the doctor’s fitness to practise). This may include obtaining limited medical records, and/or advice from a medical case examiner (CE) and/or external experts. In cases where the concerns relate to a doctor’s health, the AR may find it useful to seek information from a doctor’s treating physician, or Occupational Health (if previous involvement is referenced) to clarify the extent of the concerns. Alternatively, it may be possible to speak to the doctor’s employers to provide reassurance that any health matters are being managed adequately locally, potentially negating the need for a full investigation.

8 In relation to (c) above, allegations based on evidence which is unlikely to support a finding of impairment are those where, despite appearing to be serious, it seems likely that evidence, which can be easily obtained within Rule 4(4), would reveal that the allegation is unsupported and therefore not capable of raising a question of impaired fitness to practise. These allegations are often likely to involve misconduct.

9 In categories 5 (b) and (c) above, a case is suitable for Rule 4(4) if it appears likely that clarification can be achieved by obtaining one or two discrete pieces of information on the basis that the information can be obtained within a reasonable period of time. It may be appropriate to discuss these timescales with the relevant ELA.

**Suitability**

10 Whilst every enquiry should be considered on a case by case basis, the AR may find it useful to bear the following principles in mind when deciding whether or not a provisional enquiry is appropriate.

11 A PE may be considered suitable when performance or misconduct concerns are raised, where:
a an allegation appears confused or may be based on a misperception and we can contact external sources for clarification;

b an allegation is clear but it contains information that suggests that it may not raise questions about a doctor’s fitness to practise;

c local or third-party investigation information is available which could help us determine whether there is a fitness to practise issue.

12 A PE is unlikely to be appropriate when performance or misconduct concerns are raised, where:

a we have clear information from the complainant that raises a question about the doctor’s fitness to practise that meets the threshold for a full investigation;

b there is evidence to suggest that the health condition is being appropriately managed, e.g. that the doctor has successfully undergone detox for alcohol and is at low risk of relapse;

c the concerns are such that we would ordinarily close the case (i.e. rule 4(4) should not be used to validate a decision to close the case where the criteria for closure are met);

d an enquiry is linked to an existing investigation, where it may be more suitable to link the allegation to the existing case;

e the incident giving rise to the allegation predates another concluded case about the same doctor and the concerns have been dealt with;

f there is a significant dispute about the facts or an allegation of dishonesty that can only be resolved by establishing credibility through witness testimony or otherwise cannot be resolved by obtaining a discrete piece of information;

g the concerns relate to systemic issues rather than fitness to practise issues.

13 When a health concern has been raised, a PE may be considered suitable where:

a the allegation is clear but there is insufficient detail provided about the nature of the doctor’s health condition and how it might impact fitness to practise. This could include allegations that relate to a more uncommon or specific medical condition (such as a brain injury) where clarification is required from a specialist with clinical expertise in that area;

b a self-referral may contain incomplete information and independent verification is necessary;
c local/third-party investigation or monitoring information is available which could help us determine whether there is a fitness to practise issue, such as a copy of an Occupational Health report or copies of a regular chemical testing schedule which support a period of remission;

d treating doctor information could clarify whether a condition that could pose a risk to the public is being managed effectively

e Local employer information that the doctor is prepared to share could clarify whether risk to patients is being managed effectively

14 When a health concern has been raised, a PE is unlikely and instead a full investigation is likely to be appropriate where:

a details about the doctor’s condition necessitates the need for a GMC health assessment. This will often be required for the purpose of obtaining an up to date assessment of the risk to patients, including chemical testing;

b the illness is of recent onset so that there is little past history available to determine the potential patient safety risk posed;

c the doctor’s condition is known to affect insight, particularly when relapses occur;

d the doctor is not currently practising or is seeking voluntary erasure and the information we have received suggests a lack of insight with a risk of working while unfit;

e information indicates the condition poses a risk to patients and is not being adequately managed and needs monitoring, e.g. the doctor has no GP and isn’t accessing regular support or treatment, and/or has poor insight, and/or has a condition prone to relapse or impaired judgement;

f the health condition relates to substance use, particularly in cases where:

- the doctor concerned has taken substances that are classified as illegal;
- there is evidence of self-prescribing of drugs that are known to be highly addictive (although medical CE advice is likely to be required in these instances);
- the drugs have been obtained illegally e.g. through theft from the workplace.

g the allegations are multifactorial. Health allegations should not be closed in the Health PE process if there are connected misconduct or performance allegations that require referral to S1 investigation. Health concerns can provide mitigation where they are linked to conduct of performance concerns, so it is better to consider these in the round
When a health concern has been raised, a PE is unlikely and instead closure is likely to be appropriate where:

h The doctor does not have a licence to practice. Investigations are only appropriate where concerns about a doctor’s health pose a risk to patients. If we close an enquiry on this basis, we should place an alert on the doctor’s record so that any risk can be assessed if they apply for a licence.

i the health condition is already well documented with medical input from a reliable source and so a PE would not yield any new useful information;

Case studies illustrating the use of Rule 4(4) Provisional enquiries are set out at Annex A. Cases studies specific to Health PE can be found in Annex A to the Triage Manual for Health Enquiries.

The test at Rule 4(4)

The test at rule 4(4) is not whether the realistic prospect test is met but whether the concerns raise a question about a doctor’s fitness to practise.

Where the allegation is clear and/or there is sufficient information to make a decision, the AR should make a decision to close or promote the allegation following the usual procedure under Rule 4.

Information suitable for provisional enquiry

Medical records

It is acknowledged that, in the majority of clinical cases, relevant medical records will exist. Given the timeframe within which provisional enquiries will be conducted, it is likely that we will ask for only limited extracts from medical records and only from relevant sites.

In enquiries where a health concern has been raised about a doctor, the medical records of the doctor who is the subject of the enquiry may provide useful evidence and can be requested in accordance with our power under s35A of the Medical Act 1983 (as amended).

In performance or misconduct enquiries where medical records have been identified as the discrete information necessary to make a decision under Rule 4(4), the AR, with advice from a medical CE, must present strong reasons why they are likely to identify or clarify the issue. The AR must also specify and give reasons for the extent and type of medical records required.
22 The AR should always consider the following when directing that medical records should be requested:

a Are the records likely to confirm whether or not the allegations raise concerns about the doctor’s fitness to practise?

b Is it likely this information could enable us to close the enquiry?

**Oral or written enquiries with individuals/organisations**

23 These may be relatively quick enquiries that the AR (or delegated staff resource) can undertake in order to understand the nature of a complaint or referral. The Threshold guidance states:

“local enquiries may be more appropriate to establish whether the allegations arise out of a misunderstanding or whether there has been apparent misconduct by the doctor that we need to consider”

24 Where health concerns have been raised about a doctor, we may request input from the practitioner treating the doctor subject to the enquiry, an occupational health report, or details of absences and performance records from the employer.

**Formal investigations by public bodies (e.g. other regulators, coroners, National Fraud Office)**

25 We may receive a complaint that concerns the outcome of a formal process. We should obtain a copy of the report if the complaint gives us reason to believe that the report will resolve the issue; and the report has been produced by a credible body.

26 Given the timeframe of the provisional enquiry process, consideration should be given to whether or not the investigation is complete and, therefore, the report available. If it is not clear from the complaint whether or not a report is available, the AR should contact the investigating body to ensure that it can be requested within the timeframe.

**Medical CE advice and Expert Opinion**

27 After obtaining medical records, or relevant third party information, an IO will need to seek either medical case examiner advice, or the opinion of an external expert. Where possible, the AR should indicate which is likely to be appropriate to the enquiry.

* Paragraph 13 to the Thresholds.*
Medical case examiner (CE) advice

28 To help determine whether there is a (clinical) FTP issue that warrants investigation, a medical CE can be asked to advise whether the doctor’s actions raise a question about their fitness to practise. It will be appropriate to request advice from a medical CE regarding general medical issues that fall within the specialism of the medical CE.

29 At this stage, the medical CE is not being asked to advise whether the RPT is met. The medical CE may be asked to advise whether the standard of care ‘appears’ to raise a question of impaired fitness to practise. If the standard of care appears to raise a question of impaired fitness to practise, referral for a Stream 1 investigation is likely to be indicated.

Medical expert opinion

Performance/misconduct

30 To help determine whether there is a (clinical) FTP issue that warrants investigation, the AR can ask for a medical peer opinion. The medical peer will confirm whether the complaint contains any information that suggests the doctor’s actions raise a question about impaired fitness to practise that would warrant investigation.

31 It will be appropriate to refer to a medical peer for an opinion where we do not have the specialist expertise within the GMC. At this stage, the medical peer is not being asked to assess the standard of care but rather whether, on the face of it, the complaint raises significant issues about the standard of care. If the medical peer is of the view that the complaint raises significant issues about the standard of care, a full investigation will be appropriate.

Health

32 The AR may decide that an expert psychiatric or other medical opinion is needed. It will act as useful evidence in cases where it appears the doctor may have an undiagnosed health condition, or where we already have information about the doctor’s illness but expert advice is needed on how this might impact their practice, or whether the health concern could be linked to the doctor’s conduct.

33 The expert will be asked questions regarding whether the doctor’s health condition impacts on patient safety, taking into account any evidence received about how it is being managed. At this stage, the medical expert is not being asked to make a diagnosis or assess the doctor’s fitness to practise. Instead they are being asked to provide a view on whether, on the face of it, the issues raise a question of impaired fitness to practise that should be investigated. The IO will discuss the case with the medical expert. Guidelines for the types of question to ask are included in the Provisional Enquiry Manual.
34 Once all additional information has been collected during a PE, the AR can reassess the enquiry in light of the new evidence obtained. They should review this evidence against the Guidance for decision makers on assessing risk in cases involving health concerns and in accordance with the Provisional Enquiry Decisions guidance, in order to decide whether a health investigation would be necessary or whether the case can be closed.

*Case examiner (CE) and In House Legal Team (IHLT) advice*

35 To help delineate/articulate the issues within a complaint/referral, a CE or IHLT can be asked for advice. At this stage, the CE or legal adviser is not being asked to advise whether the RPT is met but whether the complaint raises a question of impaired fitness to practise about the doctor that should be investigated.

*Considerations for AR*

36 The AR may be able to give some indication, based on the nature of the allegations, which of the above ought to be sought during a provisional enquiry. The AR should consider the complexity of the allegations and the specialist input required.

37 The AR may on occasion feel it is appropriate to initially seek the opinion of a medical case examiner on whether or not an expert opinion is required. This will be useful where the AR has insufficient specialist knowledge to determine whether an external expert opinion will be useful, or what specialist input is required.

38 It may be the case that it is not possible for an AR to determine which of the above will be appropriate based on the initial allegations. Where this is the case, the decision should be deferred until the medical records have been gathered, and the IM responsible for the case will decide which option is the most appropriate.

**Provisional enquiry process**

*Use of personal information*

39 The AR should have regard to the overarching guidance Guiding Principles on using personal information when considering concerns.

40 If we propose to share sensitive information that relates to the complainant or a third party with external individuals or organisations as part of provisional enquiries we will need to notify the individual how their personal information will be used in our fitness to practise process and give them an opportunity to let us know if they have any concerns or specific requests about that use, unless it is impracticable or undesirable to do so for public interest reasons.
The online concerns form and the PDF and Word versions of the form, provide the complainant with details about how their personal information will be used and gives them an opportunity to tell us if they have concerns or specific requests about that use. Where a complaint is made using the online form, assuming the complainant is the patient, the issue of notifying them about the use of their personal information and giving them an opportunity to raise concerns or a specific request about that use will have been dealt with.

Where a complaint is made without using the online form, or the PDF or Word versions of the form, we will write to the complainant with a ‘Your information form’. If the complainant has not notified us of any concerns or specific requests relating to the use of their personal information within 14 days, we will usually proceed with disclosure for the purpose of making a provisional enquiry. Where the complainant raises a concern or makes a specific request about the use of their personal information, this must be considered in accordance with the Guidance for decision makers where an individual raises concerns or makes a request about the use of their personal information.

If the complaint has been referred by a Trust and contains sensitive information about third parties, our usual operational processes relating to the use of personal information will apply and we should contact the Trust in order to obtain contact details for the purpose of notifying the patients that we are using their personal information in our fitness to practise processes. If the referral contains sensitive information about multiple (3 or more) patients we can conduct provisional enquiries simultaneously with contacting the Trust.

Disclosure

The doctor and the doctor’s responsible officer should be notified before we conduct any external enquiries.

There is no requirement under the Fitness to Practise Rules for the GMC to notify a doctor’s employer of a provisional enquiry made under Rule 4(4) (a) or (b)”. The decision maker will need to consider whether or not a disclosure is required in order to request information from a doctor’s employer. Disclosure to the doctor’s employer(s) will be required in the event that an investigation is opened following a provisional enquiry.

Cases relating to the doctor’s health

*S35A(2) of the Medical Act and Rule 13 of the Fitness to Practise Rules*
Care will need to be taken to protect confidential information about a doctor’s health condition while obtaining evidence as part of an enquiry relating to the doctor’s health.

Where evidence is required from a doctor’s employer, the employer should be informed that we have opened a provisional enquiry based on information we have received, without providing any further details, and ask if they could provide any information. Useful information may include (but is not limited to) the doctor’s absence record, prescribing history, details of Occupational Health involvement, and any more general concerns the employer may have.

The doctor should be notified that we may need to seek further information about their health and asked to provide details of any health practitioners who may hold relevant information. If the doctor does not provide this information in order to facilitate provisional enquiries being made, it may be more appropriate for a full investigation to be opened so a decision can be made about whether to formally invite the doctor to a health assessment.
Annex A

Case studies

Case study one - performance
We receive an anonymous complaint from a doctor. He recommended treatment for his patient and referred him to the appropriate hospital consultant. The doctor alleges that the consultant prevented his patient from receiving the appropriate treatment and, as a result, the patient died. The complainant mentions that an inquest has been held.

The complaint raises potentially serious concerns about the consultant’s practice. Before making the decision to investigate, the AR requests the coroner’s report. The coroner’s findings show the consultant was not to blame for the patient’s death.

The case is closed at triage.

Case study two - misconduct
A health professional (Mr X) alleges that a doctor has spread false rumours about him (i.e. Mr X) having an affair with a patient, Ms A. Mr X also alleges that the doctor has exposed himself to a patient.

The allegation of exposing himself is serious enough to raise a question of impairment. However, the apparent vexatious nature of the allegation prompts the AR to make provisional enquiries to assess whether it is likely that the allegation would be supported by evidence and therefore capable of raising a question about impaired fitness to practise.

The AR checks whether we have received any information about the alleged affair with patient Ms A and finds we have received a referral from the Trust following their own investigation. The AR obtains a report of the local investigation into the alleged assault and allegation of exposure.

This report clarifies that there is no evidence to support the allegation against the doctor and that the doctor has moved practice.

As there is no evidence to support the allegation of exposure and the incident has been resolved at local level, the case is closed at triage.