

# Appendix F



## BRIEFING NOTE ON THE UNITED KINGDOM'S PUBLIC INTEREST DISCLOSURE ACT, 1998

The *Public Interest Disclosure Act* was passed by the U.K. Parliament in 1998 and came into force in January 1999. It amended the *Employment Rights Act*, 1996 by introducing new rights not to suffer dismissal or detriment for making a protected disclosure. It applies to virtually all workers in the public and the private sector.

The *Act* aims to encourage problems to be resolved within the workplace, with public disclosures to be made only in limited circumstances. (Find more details)

The *Act* applies to virtually all employees in the public and the private sector, including to National Health Service (NHS) practitioners, such as physicians, dentists, pharmacists, etc.

Section 1 of the *Act* specifies the types of behaviour, disclosure of which be protected against reprisals (called “qualifying disclosures”):

- criminal offenses
- failure to comply with legal obligations
- miscarriage of justice
- health and safety risks
- environmental risks
- concealing information about any of the foregoing

Disclosures may be protected even if they are about matters which took place abroad.

Protection applies where a worker makes a disclosure:

- in good faith to his employer or to another responsible person;
- in the course of obtaining legal advice/note there are no conditions attached to protection where a worker makes a disclosure to a legal adviser;
- in certain cases, to a government minister; and
- to a person or body prescribed by the Secretary of State.

In all cases, protection applies provided that the worker acts in good faith, reasonably believes that the information falls within the potentially protected categories and is substantially true.

Protection is provided for workers who make “external” disclosures, that is other than to the employer, a legal adviser or a prescribed person. Significantly, a worker making external disclosures will only be protected if he/she has previously disclosed to the employer or a prescribed body, or has not done so because of reasonable belief of reprisal or the concealing/destruction of reprisal or the concealing/destruction of evidence. Whistleblowers must not act for personal gain.

Any terms in an agreement between a worker and his/her employer are void if they preclude or restrict whistleblowing (the so-called contractual “gagging” clauses).

Employees are not to be subject to detriment for making a protected disclosure. “Detriment” may include any action against an employee, for example, demotion, failure to give a promotion or training or withholding a pay increase. Contract employees can claim under this if their contracts are terminated. Because regular employees can claim unfair dismissal the right to complain of detriment does not apply to employees who are dismissed.

A tribunal is created to enforce the *Act*. In deciding whether the worker acted reasonably the tribunal will take into account all the circumstances, including particularly:

- the identity of the person to whom the disclosure is made;
- the seriousness of the matter;
- whether the problem is continuing;
- whether the disclosure is in breach of the employer’s duties of confidentiality to any other person;
- any action the employer or the prescribed person might reasonably be expected to take as a result of a previous disclosure;
- whether the disclosure was made in accordance with any internal procedures approved by the employer.

Since the *Act* comes into force only in 1999, evidence on its impacts is difficult to locate.

In the case of the health field, the *Act* operates within the context of wider reforms to strengthen accountability of health providers to government and to the public. The Labour government of Tony Blair, elected in 1997, issued a white paper “The New NHS: Modern, Dependable (1997) which indicated that the government would “strengthen the existing system of professional self-regulation by ensuring they are open responsive and publicly accountable” (p. 97). This was followed by the announcement that for the first time hospital trusts would be held legally accountable for the quality of service they provide. Another document “A first class service: Quality in the New NHS” (1998) proposed a comprehensive, management-led system of clinical governance designed to set and monitor clinical standards. Self-regulation remains, but it must be modernized to ensure that it is:

open to public scrutiny; responsive to changing clinical practice and changing service needs; and publicly accountable for professional standards set nationally and the action taken to maintain those standards (DOH, 1998, para. 3.44).

“Government,” says the document, “will take responsibility for clarifying which treatments work best.” This statement represents a fundamental shift, if it happens: the government is proposing to take ultimate responsibility for clinical standards. There is the question of whether the NHS can fulfill this responsibility through the proposed National Institute for Clinical Excellence (NICE) which would perform clinical evidence collection and appraisal functions. There is also the question of whether governments will regret taking in part at least the responsibility for clinical standards away from the professions because governments will become more direct targets for patient dissatisfaction with clinical decisions.

In 1999, the Blair Government issued another consultation paper, “Supporting doctors, protecting patients’ (MHS, 1999) setting forth an array of proposals designed, first, to prevent problems and, second, to deal with deficiencies in performance. Among the key recommendations were:

- greater guidance and supervision to doctors in training

- appraisal of performance of doctors will become comprehensive and compulsory and will become part of the “revalidation” process operated by the General Medical Council;
- participation in clinical audits will become mandatory for both hospital doctors and GPs.

In addition to these preventative steps, the government proposes to deal with poor physician performance by abolishing existing disciplinary procedures and substituting a new integrated process involving NHS and the several professional bodies. In simple terms, there would be three steps for dealing with doctors with problems:

- serious clinical problems or mistakes would be referred immediately to the General Medical Council (regulatory body) whereas less serious doubts about clinical performance would be referred to an Assessment and Support Centre (see below);
- Assessment and Support Centers would be established to work with doctors to correct deficiencies in performance. Remedial actions could take a number of forms: return to practice, monitoring of practice, re-education followed by reassessment, referral back to the health authority as a serious and intractable problem and referral to the GMC
- the employer or health authority would accept responsibility for implementing findings of the Assessment and Support Centre, with provision for the doctor to appeal actions.

The consultation paper claims to propose a system which balances the interests of the profession, the regulatory bodies, the NHS and the public in a fair and flexible manner. Submissions on the paper closed in March, 2000 and what action, if any, has been taken on the proposal is unknown at this time.

A P P E N D I X F

