Letters

Definitions

SIR
Robin Downie (1) argues not only that definitions are not always necessary but that they can be undesirable if they 'foreclose speculation'. In support of the former assertion he says 'we can all meet a friend at 8pm for dinner without being able to define time or space, and medical treatment can proceed independently of definitions of disease or health'.

This is such an enormous philosophical claim and the implications for health care practice are no less sizeable, that it cannot be let pass. Downie says that we do not need definitions of space and time to meet another person at a particular place and time. However, what he should be saying is that we do not need comprehensive definitions of space and time to do this. Downie's claim, as he puts it, is false, since in order to say meaningfully: 'I shall meet you outside Mamma Mia's Pizza Parlour at 8pm this evening' some definition of space and time is both necessary and implicit. If I understand that the pizza parlour cannot be in the same place as the church and that its location is relative to the position of other buildings, and if I understand that 8pm is not 7am then although I do not have a physicist's concept of space-time I most certainly do have a clear and useful definition of space and time. At the very least, to make the dinner arrangement, one has to have an ostensive definition of space and time (even if I could not tell the time and did not have even a rudimentary understanding of the word 'space', if I were to meet my friend I would have to be told 'I shall meet you there not there when the hands of this watch are here – you must come when it is dark not when it is light').

Now, if it is true that definitions are essential for us to deal with non-problematic everyday matters, how much more important they must be in matters which involve vital human values such as health. To think that they are not important in such cases is simply to aim to preserve the status quo by default rather than argument. A parallel illustrates this point: space and time can be defined in various ways but if the words are to make any sense they must be defined in some way. Exactly the same is true of health. The World Health Organisation defines 'health' in one way, I define it in another, most governments define it in yet another. Because of this pluralism, and because most people do not find the word 'health' problematic in everyday use, Downie concludes that discussion of the issue will not be fruitful and that a definition is not required. But look what this view implies. Just as actually doing something – meeting a person at an arranged place and time – acts implicitly to confirm (to both parties) that their definitions of space and time are accurate, so the everyday doing of technical activities (those mainly medical things done within a health service, for instance) in the name of health confirms that traditional (implicit) definitions of health are accurate. But just as there is a lot more to space and time than hours and metres so there is a lot more to a full, defensible and ethical theory of health than stethoscopes, bed pans and surgical skills, as those who try to develop philosophical theories of health (from which practically useful definitions can be derived) are passionately aware.

The act of clarifying and developing philosophically sound definitions of concepts central to human life should not be devalued. It is not this task which 'forecloses speculation', far from it. Rather it is the casual acceptance of evolved, often unplanned and often unsatisfactory practices as defining what ought to be the case that does this.

Reference

Response to Seedhouse

SIR
David Seedhouse claims that 'if I understand that the Pizza Parlour cannot be in the same place as the church ... and that 8 pm is not 7 pm ... I most certainly do have a clear and useful definition of space and time'. What is it? He doesn't say. Perhaps, as he goes on to suggest, what is involved is an ostensive definition of space and time. But pointing at locations or dials is not any kind of definition of space and time, because the very process of pointing, or any spatial or temporal description whatsoever, presupposes that one already has an awareness of space and time. The ideas of space and time, as Kant pointed out (1), are integral to human consciousness and therefore cannot be picked out and defined as can complex empirical ideas.

As for health, I tried to make it plain in my article that the World Health Organization (WHO) (whatever they claim) are not defining health. What they say is not an account of how the word is used, or what it refers to, or an analysis of it. What it is is the statement of a recommended policy. The WHO were telling us to pay attention to the mental and social as well as the physical. Now of course one can argue about the WHO policy and other public policies, but these arguments have nothing to do with definitions.

Consider two examples. It is possible to argue until the cows come...
home as to whether fitness is or is not part of health, or whether alcoholism is or is not a disease. Such arguments can get philosophy a bad name (‘Just semantics’ the doctors say). What is important is debate as to whether fitness programmes are a desirable part of public policy, and what is to be done about alcoholism. Debates of that kind can proceed independently of definitions, and philosophers do better to engage in discussion on such public policy issues than to lock themselves into the Platonic world of definitions.

Reference

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Confidentiality as fair agreement

SIR
Reading Professor H E Emson’s article, Minimal breaches of confidentiality in health care research: a Canadian perspective, Journal of Medical Ethics 1994; 20: 165–168, raises questions, beginning with his consideration that to believe in absolute confidentiality is ethically dubious. An absolute stance may be wrong or inadequate, but surely not dubious?

Emson’s major point seems to be that chart-based research justifies ‘minimal breach[es] of confidentiality’. But: 1) Such research is considered of limited scientific value and when benefits are sparse, costs must be reduced all the more, and even minimal breaches of confidentiality may be unacceptable, 2) Emson lists only academic benefits from chart-based research so that there really is no excuse for any costs, including minimal breaches of confidence, for investigations that do not benefit either the involved or any other patients and which are not allowed to be harmful in any way.

Towards the end of his paper the author mentions a local Privacy Act which permits disclosures in accordance with the previous agreement of involved ‘person[s] or bod[ies]’. If there is agreement as to the conditions of the ‘subsequent disclosure of information’, this surely implies that the management of information prior to this ‘subsequent’ stage of informational flow has also been agreed upon. This seems like a fair, clear and explicit arrangement about the limits between confidence and disclosure, where parties signing such contracts are aware of and abide by these clauses. Such a stance is quite different from Emson’s previous train of thought, where he assures us that the law implicitly embodies what ethics has already sanctioned. Examples in history are numerous and well known, and they principally concern privileges, discriminations, persecutions and other very unethical social behaviour.

Bioethics needs not take the law as unassailable; its function, rather, is to question the law as to the solidity of its ethical foundations and openly to discuss whether it is ethically defensible to abide by a bad law. So, it would not seem sound to suggest that an existing law ‘may be construed as expressing society’s belief …’, and that tacit arrangements are valid because they have not been overtly disclaimed. Neither the law nor its purported ethical implications can replace the assurance to be gained from clear-cut and detailed agreements.

A breach of confidence does not only constitute the indiscretion of passing on personal information; its maleficence lies in disclosing against the wishes of patients or against agreed-upon rules of confidentiality. The absoluteness of confidentiality lies not in hermetism, but in loyal and unrestricted adherence to the terms agreed upon between patient and physician. It is the agreement that remains absolute, not the limits of confidentiality as such. Since agreements may vary, confidentiality certainly can be mobile, and therefore Emson interprets me wrongly when he supposes I defend an immovable confidentiality, a term I have never used. When disclosure is accepted or tolerated by the patient, be it for reasons of legality or academic pursuits, the physician is not dispointing, much less violating, the confidence placed in him or her. At the most, he may occasionally be trespassing the limits of good taste.

What it all boils down to is that no degree of confidentiality may be unilaterally cancelled by the physician, and that whenever making charts public risks a breach of anonymity or some other indiscretion or puts the affected at any even minor inconvenience or risk, it is not permissible unless consent has been secured.

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In response to Szasz

SIR
Under the heading For debate, the Journal of Medical Ethics (September 1994, volume 20, number 3) published an article entitled ‘Psychiatric diagnosis, psychiatric power and psychiatric abuse’, authored by Thomas Szasz. I was puzzled by the timing of this publication since, as Dr Szasz states in the article, he has been making these assertions ‘over the past 30 years’.

I respect Dr Szasz’s strong assertion of ‘libertarian’ rhetoric. His critiques were especially relevant in the 1960s. In the context of the 1990s, however, Dr Szasz’s ideas are anachronistic. He is struggling against the development of empirically derived diagnostic criteria with out-dated rhetoric that grows weaker each year.

In the United States, there is widespread awareness now that ‘permitting’ the mentally ill ‘to die with their rights intact’ was poor public policy. Once again, Dr Szasz has little awareness of the real world of policy debate. While the questions raised in the paper do require review by successive generations of ethicists, the argument and rhetoric of Dr Szasz are stale even though they are advocated passionately. Would the Editor be willing to have an article that would update the debate in 1990s’ contexts?

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We are always happy to receive papers challenging, with reasoned argument, other papers published in the journal.—Editor.

In defence of ageism

SIR
Mr Rivlin (1) makes one valuable comment on my paper on ageism (2). It is not really ageism to maintain that age is one of the many factors which must be taken into account when taking painful rationing decisions. It is simply just and sensible. Unfortunately an extremist attitude