

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

- (1) Kant I. *Critique of pure reason*. London: Transcendental Aesthetic, J M Dent, 1934. First published 1781.

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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 disappointing, 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