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.

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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

that age must never be considered has arisen.

Otherwise he attacks the paper by extrapolating it. Few 'ageists' are so extreme as to impose arbitrary age-limits on treatment. Everyone accepts old people want to live. We are discussing enforced choice. Nobody thinks cost-effectiveness should be the sole criterion for treatment.

When I ask people if they would save a thirty-year-old or an eighty-year-old, if forced to choose, all give the same answer. Perhaps Mr Rivlin would toss a coin? Perhaps that is a cop-out? Would he toss a coin if it were his own family?

The moral arguments for the 'ageist' approach are threefold, a fair innings, cost benefit, and public approval. The last is the grandmother argument I cited. Most eighty-year-olds would accept that the life of a twenty-year-old grandchild was more important than their own. Therefore it is reasonable for society to make the same general choice. It is not relevant to say that we older people might not sacrifice ourselves for another's grandchild.

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Teaching medical ethics

SIR

I enjoyed Shimon M Glick's article on 'The teaching of medical ethics to medical students' (1). I was amazed to see that there are many similarities in ethical thinking and behaving between Israel and Hungary. In fact, there seem to be more similarities than dissimilarities in the whole world, and not only between these two countries. For instance, isn't it a global phenomenon that there are, indeed, some individuals, mostly physicians, who question the entire enterprise of teaching medical ethics to medical students? For those who doubt its value, it is enough to copy the behaviour of a professor, or perhaps to teach a few common-places as, for example, the physician is like the captain of a ship who has to make life-and-death decisions, therefore he/she has to assume a great responsibility. By glorifying and mystifying the medical profession and appealing to the vanity of future medical doctors, the holders of such views reveal they think that that is all ethics could and should offer. Nevertheless, sometimes this approach seems to work well, provided that the teacher can really serve as a model for respecting patients, both their dignity and uniqueness. Although this leads to paternalism, it is still better than any kind of nihilism that denies the moral components of medicine.

I could not understand – and certainly cannot share, even if it is a general belief – the idea that the basic moral character of medical students has been formed by the time they enter medical school. If that were true then how could one explain another general phenomenon, stated by Professor Glick himself too, that there is such a thing as pre-cynical and cynical years during medical training? Shouldn't that rather be viewed as a change in the basic character of the students? Teaching of medical ethics should, indeed, help to develop ethical reasoning and develop moral sensitivity but why ought we to make such efforts if we believe that basically we cannot change the students' character? Only 'to prevent the erosion that almost invariably occurs in those qualities during the medical school years'? This would only be a minor compensation compared with the goals we set out to achieve.

It is certainly an appealing and useful idea to involve talented people of various fields in ethics teaching of medical undergraduates. We have been doing it in our university for more than a decade now, and feel that such people can be very valuable in leading seminars, especially if – besides being interested in bioethics – they are highly committed to the work of teaching ethics. Indeed, they can be very refreshing and supportive. I do envy, however, Shimon Glick's university for being willing to have, and being capable of having, the students enjoy an early clinical exposure. It would be interesting to know how much any dehumanisation of the physician/patient encounter might be blamed for the lack of such an early exposure. The strictly somatic approach most likely has some of its roots in the perfect isolation of basic scientific subjects, with no clinical input at all, which occurs in the first two years of medical school. This separation surely hinders the development of 'appropriate compassion or sensitivity', and the lack of this, I, too, would call an unethical practice of medicine. Bioethics should be an integrated part of medical training but it can be done only where university leaders believe that the moral issues of medicine and health care amount to much more than assuming the responsibilities of a ship's captain.

Finally, while agreeing with the writer's questioning of absolute truth-telling, I must express my reservations concerning his belief in the demand for the concealment of bad news, supposed to be characteristic of Eastern Europeans. My experience, and various surveys carried out in regard to truth-telling, indicate that if a health institute is not run as a prison and the atmosphere is open and humanistic, then about 80 per cent of the people want to know the truth, even if it is devastating (2). It is well known that there are many ways to tell the truth. If the actual truth-telling is to be brutal, untimely, unprepared and disgraceful then certainly not many individuals will want to know the truth. In my view then, it is rather the circumstances surrounding the actual giving of information rather than a particular culture which determine the acceptance or refusal of such a principle of truth-telling.

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