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Commentary 1: Confidentiality: the dangers of anything weaker than the medical ethic

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Much of the discussion which appears in this journal and elsewhere arises because of developments in modern technology. The discussion of medical records by Mr Kenny and Dr Pheby comes from developments in modern bureaucracy. They imply it is as wasteful to attempt to hold back the developments of the latter as it is those of the former. With bureaucracy, as with technology, the changes in society force not only more precise definitions of principles and rules of law and ethics

but also a refinement of them. If we fail to understand the issues, we merely fudge, but do not avoid the refinement. If we differ as to our perception of the issues then it is likely that we will differ as to our definitions.

It is not surprising that these authors provide a challenge to what may be called 'the normal medical view'. The one is an administrator and the other a community physician. As the practice of medicine has grown in complexity so also have the demands of its administration increased. There is little point in members of the two oldest professions (law and medicine) dismissing 'health administration' as not a true 'profession'. The hospital remains a place where the physician can practise his craft but it is no longer a place where he can do so without the skills of those who link the galaxy of personnel of the healing professions, ie its administration.

Community medicine has, of course, always been the poor relation of the surgeon and physician. Over the last 150 years its triumphs have rarely been dramatic but any view of the history of medicine must be prepared to concede its major contribution to the achievement of medicine's goals (1).

It appears that both these authors may have relied too heavily on the existence of interdisciplinary practice. No doubt, as with any of us, their perspective has influenced their perception. Put briefly they are saying that since much of modern medicine is based on such a therapeutic team, older understandings of the basis of medical confidences may have to be modified. Certainly, Kenny is right to point out that the doctor does not have contractual or functional control of many members of the team. However, it is questionable as to whether or not this affects the patient's perception. Surely he still looks to the doctor rather than the institution for his clinical care. Also Pheby is right to make the distinction between hard and soft data in the casenotes and certainly he is right to object that because an entry appears under the hand of a doctor it is not thereby an objective truth. Both physicians and others in the health care teams are capable of making value-laden assessments and of overlooking or forgetting this fact. He is also right to point out the lack of legal remedies for mistakes arising from this fault.

Before proceeding to an examination of either law or ethics, it is important to clarify what medical records are and for what they are used. Broadly, the record will contain information from four sources:

- 1) Information given orally by the patient,
- 2) Maybe, information given by others,
- 3) Information generated by the doctor from his own observation (which will include the diagnosis and prognosis), and,
- 4) Information acquired as a result of X-rays, pathology tests etc which may itself come from either the doctor's own work or from others.

Records are used, says Benjamin (2), as an aid to treatment, as an instrument of teaching and research, as a source of statistics particularly to aid management in its planning and as an aid to epidemiologists. It is also important to note that although both law and medical ethics speak of confidences they have always done so on the basis of separate and distinct principles which occasionally overlap and at times conflict.

In order to discuss the law of confidence, it is helpful, as Kenny does, to avoid confusion by separating it from matters, which although practically related, are not analytically related. Thus we can usefully avoid discussion of the ownership of the copyright or of the paper upon which the record appears. So also can we avoid discussion of any claimed right to privacy (3). Whether confidential information is a form of property presents its own peculiar technical problems. Even to the lawyer it is not productive to speculate as to its 'owner'. To the lawyer it is more useful to have regard to the breach of the confidence, *ie* who can complain about whom for it, or, in his language, to whom and by whom is the duty of confidence owed.

The Law Commission have recently said the action for breach (4):

may be described as a civil remedy affording protection against the disclosure or use of information which is not publicly known and which has been entrusted to a person in circumstances imposing an obligation not to disclose or use that information without the authority of the person who imparted it.

Thus, if P (a patient) gives information to D (a doctor) and D gives it to A (an administrator), both P and D may be able to complain that A has disclosed or used the information in an unauthorised way. Further if we apply the Law Commission's description to the sources of information in the medical record (above) it is clear that the action for breach of confidence is an imperfect instrument for preventing medical records from disclosure because the person *about whom* the information is compiled is only owed a legal duty in respect of a part of it. The doctor and the institution who compile the whole record will of course be able to maintain an action for uses they have not authorised. This almost takes us to Kennedy's concept of 'custody'.

However, the patient is owed a duty in respect of at least part of the record. Disclosures he has not authorised may be remedied by his litigation. Usually it will be implied that information supplied to the doctor is authorised to be disclosed within the therapeutic team for clinical purposes and these will include Benjamin's listed uses (above). In law, however, the authority is that of the patient. Except in this consensual way, the giver of information maintains his control over its use. The recipient does not have the legal right to release himself from the

duty nor an absolute right to say he will receive only information free of the duty.

Thus under the current law (and indeed under the Law Commission's suggested statutory right), Kenny's proposal, in so far as it implies that a health authority may include in its policy for data protection the grounds on which the information may be released, is unworkable.

There are four further legal factors which are relevant. Each of them, it is suggested, applies to the whole record and not merely that part which is generally protected by the legal duty of confidence owed to the patient. First, the law of confidence does not protect information indicating an 'iniquity' or 'misconduct': there is said to be a public interest in its proper disclosure. It seems that this is sufficient, in some cases, to afford a defence to an action for breach. But the fact that there is misconduct etc does not require the disclosure. Whether or not it should take place is dependent upon a large number of factors including some ethical considerations. It would seem that these factors are similar to those to be applied as regards information indicating misconduct coming from sources other than the patient, *ie* they are applicable to the whole record.

Second, although legal duties to protect confidences exist independently of contract, they may also be created by contract. Therefore, it is possible for my doctor to contract with me that he will protect my medical record. In such cases there is no necessary reason why the contract should be held to imply that I should be able to see the record unless this is specifically stated. All such a contract would do is to give me an action against my doctor for the unauthorised release to third parties. I would gain no further rights against these third parties for their abuse of his confidence. It must also be noted that such a contract (in the strict legal sense of the term) is not possible where the relationship of doctor and patient arises within the NHS.

Third, there are occasions when the law requires the disclosure of the medical record irrespective of confidence with which it is impressed. Among the most important of these is the power of the court to order discovery of the record in personal injury actions either where medical malpractice is alleged or where the court needs to know the extent of the injuries in order to assess the compensation the victim of an accident ought to receive. In such cases the court has power to compel disclosure either to the patient himself, or to his legal advisors or to his medical advisors (5). There is little guidance on the grounds upon which the court will distinguish these types of disclosure. It does appear that the fact that a duty of confidence is owed will not be particularly important; more regard will be given to the nature of the litigation and of the medical record.

Fourth, it has been suggested (6) that the legal position is different where psychologists, and we may presume doctors, are employees. It was said

that since they acquire information as employees, their employer may use it for any of his activities. It is difficult to see any justification for this view. First, as the Law Commission says, if information is supplied for one purpose it may not be used for another. Second, where an employee must have a professional qualification in order to be employed it is most likely that the court will imply a term into the employment contract that he should act in accord with the rules of that profession (7) and this will include professional restrictions on the use of information.

Thus in some crucial respects the law throws itself upon an assumed prior obligation to respect medical confidences. For many, this respect is itself based on the Hippocratic tradition of medicine. Within that tradition the duty of confidence arises in two ways. First, as is well-known, the Hippocratic Oath provides an undertaking along the following lines: 'And whatever I see or hear when attending the sick, or even apart therefrom, which ought not to be told, I will never divulge but hold as a secret'. This aspect is reflected in modern codes of medical ethics and also in similar codes applied by the General Dental Council, the General Nursing Council and the Council for Professions Supplementary to Medicine. The second aspect of the Hippocratic relationship to the duty of confidence is more wide-ranging. It is expressed in the Oath in words such as: 'I will teach . . . to my sons, the sons of my teacher and to pupils who have sworn the Oath of a Physician but to no one else'. Cartwright argues that (8)

if we examine the Oath critically, we see that the essence is a promise to support members of the group, to confine teaching of the art to a closed circle, and not reveal the mysteries to anyone outside that circle. It embodies a high ethical standard. . . . Thus the Hippocratic Oath ensured a 'closed shop' and this closed shop persists today in the differentiation between the privileged registered practitioner and the unregistered quack.

On this basis it is here suggested we have an explanation for the free exchange of medical confidences between physicians and the great reluctance to let control over them pass outside that closed professional circle (9).

At the philosophical level, Beauchamp and Childress say there are both utilitarian and deontological reasons for medical confidences (10). The utilitarian reasons relate to such matters as the need for the physician to know. If the patient feared disclosure harmful to his perceived interests he might become reluctant to tell all. The deontological reasons rest on one of the four major principles they describe – the principle of autonomy. In this aspect it means the right of the patient to control the flow of information about himself – itself an aspect of the right of privacy.

These authors do not reject the 'ethics of virtue' but they do not consider them of primary importance. A patient, they say, is not safeguarded by the moral goodness of his doctor. Hence their analysis easily lends itself to a translation from ethics into legal rights. A right of privacy should be created at law, if only to reinforce the ethic. Space prevents a more detailed criticism of their well-argued thesis. It suffices to say that if it were to be accepted, medical practice in Britain would almost inevitably be subjected to greater legal regulation. A consequence of this is quite possibly that the reliance on the ethic of virtue that the profession now has would be reduced. Therefore since the reliance would be less the emphasis would be less; and because the emphasis would be less the effects would be diminished. Thus, the more we introduce legal rights, the more we change the basis of the practice of medicine.

It would seem that a wise policy for the control of medical information would be to keep the advantages of the older machinery, both legal and sociological. The Lindop Committee in England thought (12) that at present it was not appropriate for the patient to be given a right to see his record although they were prepared to disclose the 'purely factual data'. They did not want the patient to see the rest 'because knowledge of his condition might harm the patient and because such data are sometimes speculative and uncertain'. In Canada, the basis of medical practice is more contractually orientated than here. In a report of an Ontario Royal Commission, it was recommended (13) that as a general rule a patient should have access to his own record. A doctor would have the right to refuse but a Health Commissioner could investigate and overrule him.

It is probably true that the British medical profession does not fully appreciate the implications that the lack of a contractual relationship with patients has for the structure of its practice. In this instance standards are maintained by peer review. It is this mechanism for review which is so useful in emphasising the ethic of virtue. Such an ethic is not easily applicable to individual cases. Once a doctor is compelled to justify a particular decision not to disclose, much of its rationale has gone. It is because peer review in the medical profession is at once both more powerful and more widely acceptable to the outside than any other type of peer review that concern must be expressed at anything that weakens it. Neither Beauchamp and Childress nor Kenny nor Pheby directly advocate anything like 'cook-book' ethics. Nevertheless reliance on codes of conduct less powerful than medical ethics or a machinery less effective than that applied in the UK could lead to such. Herein lies the danger of Kenny's and Pheby's attempts to take realistic account of the interdisciplinary nature of much of modern therapeutic practice.

References and notes

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- (4) *Report on Breach of Confidence*. Cmnd 8388. London: HMSO, 1981: para 3.1.
- (5) Supreme Court Act 1981 sections 33–35. This repeals and re-enacts with amendments the provisions of the Administration of Justice Act 1970 sections 31 and 32. The amendments concern clarification of the Court's power to confine the disclosure to medical or legal advisors. It reverses the rule in *McIvor v Southern Health and Social Services Board* [1978] 1 W L R. 260.
- (6) Jackson M. Psychologists lose right to keep reports secret. *Times Educational Supplement* 1981 Aug 14.
- (7) *Tarnesby v Chelsea and Kensington and Westminster (AHA) (T)* [1981] 1 R L R. 369.
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- (9) *Handbook of Medical Ethics*. British Medical Association, 1980. This book insists on the doctor's ultimate responsibility for medical confidences.
- (10) Beauchamp T L, Childress J F. *Principles of Biomedical Ethics*. London and New York: Oxford University Press, 1979: 209–217.
- (11) See reference (10) p 234.
- (12) *The Lindop Report*. See reference (2) para 24.05.
- (13) *Report of the Commission of Inquiry into the Confidentiality of Health Information*. Toronto, Ontario, 1980; Chaps 16, 23. The former deals with the supply of medical information to the police.

Commentary 2: Confidentially speaking

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Few doctors now take any form of Hippocratic oath when they qualify, they just learn medicine and are grateful to pass their final exams. However, whether or not they have discussed ethics as students, they will usually have some idea that it is not ethical (etiquette) to break confidence with patients who tell them about themselves. They may read in the generally unhelpful short texts on medical ethics that it may be illegal to withhold information from a

court – but that it would not be ethical to divulge confidential information to other people without the patient's consent. Does the doctor's position differ from the priest in the confessional? There has been considerable discussion about the intentional or unintentional disclosure of patients' records, thus breaking confidentiality, but there has been somewhat less concentration on the verbal breaking of confidences. Is there any essential difference between documented records and the spoken word?

How carelessly do we give away personal information to all and sundry, let alone to a judge who is threatening us with committal to prison for contempt of court, which might harden our resolve to stay silent, sometimes without any reason to suppose that it might benefit our patient? Are there times when we should tell other people private details without a patient's permission, in the hope that they may be helped, or to protect others from possible harm, or just in the general belief that the 'law of the land' should be upheld?

Mixed up with the issue of ethics and confidentiality is the way that many of us probably do chat about patients, to medical colleagues and students, and even with our relatives and friends, and sometimes casual acquaintances. At the same time, even if we are conscientious in protecting our patients' confidences how much do we really take them into our confidence and tell them about their diagnoses, management, medication and so on in a one-to-one relationship rather than with the all-too-common God-child paternalism so often seen in doctors?

To what extent are patients consulted about their confidential rights in the teaching setting? They should, of course, be told 'this is a teaching hospital' and tacitly acknowledge that non-medical and even unqualified people are present when they are talking to the consultant or other doctors on the team, and these other people will know something about the patients' private lives. The accepted physical presence of other people during a doctor-patient discussion, usually nurses or medical student, and sometimes a social worker, may be tacitly assumed to have given the doctor permission to proceed with the other person(s) present. The patient may, wrongly or rightly, assume that these other people are bound to the same confidentiality as exists with the doctor. There seems to be no other general situation where the doctor can assume any implicit permission to broadcast any private information.

Another aspect of the teaching situation is the need to ask patients to consent formally to photographs being taken for teaching purposes, rather than just to be filed in the notes as a medical record. With the increasing use of video equipment in general practice as well as hospital, and the way in which video material lends itself to clever editing, a doctors may learn to their cost, it is possible that