the posterior element stress fracture, which often fails to heal even after a prolonged period.[9] With immobilisation, however, the lesion in this case does not seem to have progressed over two years, and we have therefore not yet taken a biopsy specimen.

The clinical, radiological, and scintigraphic findings in these patients support the concept of the "mobile segment" in longstanding ankylosing spondylitis, which produces a characteristic symptom complex of localised pain exacerbated by exercise. The continuous movement at this level produces the extensive destructive changes that have been referred to as spondylodiscitis or pseudarthrosis.[2,8] If patients complain of this characteristic pain a mobile segment should be sought by scintigraphy and tomography so that the correct treatment is offered and further severe backache prevented.

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Philosophical Medical Ethics

Confidentiality

RAANAN GILLON

The principle of medical confidentiality—that doctors must keep their patients' secrets—is one of the most venerable moral obligations of medical ethics. The Hippocratic Oath enjoins: "Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret."[1] The obligation is widely regarded as being exceedingly strict. Indeed, according to the World Medical Association's International Code of Medical Ethics it is an absolute requirement, even after the patient's death[2]: an absolutist claim echoed in a leading article in the *BMJ*.[3] (Ironically, two years later the General Medical Council (GMC) officially indicated to the editor of the *BMJ* that an obituary he had published of a famous soldier had transgressed medical confidentiality).[4] In France so strict is the obligation of medical confidentiality that it is apparently enshrined in law as an absolute medical privilege which no one, including the patient, is allowed to override, even when to do so would be in the patient's interest.[5]

In practice, on the other hand, doctors do not seem to regard confidentiality as an absolute requirement, as many relatives of seriously ill patients could testify. The BMA handbook of medical ethics lists five types of exception to the need to maintain medical confidentiality[6] and the GMC lists eight.[7] Recent British governments certainly do not regard medical confidentiality as absolute: one of Mrs Thatcher's governments tried (unsuccessfully, largely as a result of opposition from the BMA) to give statutory licence to the police to search medical files,[8] and the BMA is still unhappy about the inadequate protection afforded to health records by the Data Protection Act 1984 and has cosponsored an interprofessional working group partly to tighten up the Act's provisions for medical confidentiality.[9] The campaign led by Mrs Gillick—legally successful though under appeal to the House of Lords at the time of writing—clearly believes that doctors are excessively concerned with confidentiality when it comes to prescribing oral contraceptives to girls under 16[10]; its members would presumably approve of the famous (or infamous) action of Dr Browne, who broke medical confidentiality and told his 16 year old patient's parents that she was taking the pill[11] (he was not censured by the GMC). Doctors express concern about both the threats to[12] and the relaxing standards of[13,14] the medical profession's principle of confidentiality, and one doctor has advocated that patients ought to keep their own records to preserve their confidentiality.[15] So was the American doctor right who called medical confidentiality "a decrepit concept"?[16] How can any sense be made of what may appear to be a chaotic jumble of attitudes?

Imperial College of Science and Technology, London SW7 1NA
RAANAN GILLON, MB, MRCP, director, Imperial College Health Service, editor, *Journal of Medical Ethics*, and associate director, Institute of Medical Ethics

What is "medical confidentiality"?

Some preliminary (and sketchy) analysis of the issues may be useful. What is meant by "medical confidentiality"? Is it morally valuable in itself or, if not, why is it morally important? Is it an absolute requirement? How does it relate to other obligations?

Essentially medical confidentiality is the respecting of other people's secrets (in the sense of information they do not wish to have further disclosed without their permission). There is obviously no general moral duty to respect other people's secrets (imagine a thief whom one had surprised saying "Shh, don't tell the police, it's a secret"), yet equally obviously doctors (and, of course, other groups) voluntarily undertake some general commitment to keep their patients' or clients' secrets (imagine the same thief talking about his activities in the course of a medical consultation). It seems

clear that two conditions are necessary to create a moral duty of confidentiality: one person must undertake—that is, explicitly or implicitly promise—not to disclose another's secrets and that other person must disclose to the first person information that he considers to be secret. Thus there can be no transgression of confidentiality if the information is not regarded as secret by the person giving it; equally it is only because doctors have undertaken not to disclose patients' secrets that they have acquired a duty of confidentiality.

Why should doctors from the time of Hippocrates to the present have promised to keep their patients' secrets? If confidentiality is not a moral good in itself what moral good does it serve? The commonest justification for the duty of medical confidentiality is undoubtedly consequentialist: people's better health, welfare, the general good, and overall happiness are more likely to be attained if doctors are fully informed by their patients, and this is more likely if doctors undertake not to disclose their patients' secrets. Conversely, if patients did not believe that doctors would keep their secrets then either they would not divulge embarrassing but potentially medically important information, thus reducing their chances of getting the best medical care, or they would disclose such information and feel anxious and unhappy at the prospect of their secrets being made known.

Such consequentialist reasoning might well be accepted not only by utilitarians but also by many deontological pluralists. Deontologists, however, are unlikely to accept it as being adequate. They are likely to base their arguments for confidentiality not just (if at all) on welfare considerations but also on the moral principle of respect for autonomy[17] or sometimes on a putatively independent principle of respect for privacy,[18] which is seen as a fundamental moral requirement in itself.[19 20] Thus, while the principle of medical confidentiality is not defended as a moral end in itself, it is defended by utilitarians and deontologists alike as a means to some morally desirable end—the general welfare, respect for people's autonomy, or respect for their privacy.

Medical confidentiality an "absolute" principle . . .

I have given reasons in previous articles why both utilitarians and pluralist deontologists would not be able, and would not try, to make a principle such as medical confidentiality into an absolute principle, whereby a patient's confidences invariably had to be respected whatever the consequences (though the duty of confidentiality of the Roman Catholic confessor appears to be regarded as absolute). I have also argued previously that although the Kantian categorical imperative is regarded as an absolute principle, it necessarily requires the interests of all affected rational agents to be taken into account in its application; Kantians too would thus have no place for a maxim that demanded absolute medical confidentiality in all circumstances. Nor, incidentally, would there be any philosophical justification within these systems for the requirement of confidentiality to be absolute after a patient's death.

Such philosophical reluctance to see medical confidentiality as an absolute requirement is matched not only by various modern codes of medical ethics (though not by the World Medical Association's international code) but also, I suspect, by the Hippocratic Oath itself. The qualifier, "which ought not to be spoken of abroad," though ambiguous, can plausibly be taken to imply that the oath envisaged circumstances where it was permissible for information obtained in the course of a doctor's professional activities to be "spoken of abroad." In general the medical profession in Britain today probably sees confidentiality as a strong but by no means absolute moral obligation. The GMC's "blue book" lists the following eight legitimate exceptions: (*a*) when the patient "or his legal adviser" gives written and valid consent; (*b*) when other doctors or other health care professionals are participating in the patient's care; (*c*) when the doctor believes that a close relative or friend should know about the patient's health but it is medically undesirable to seek the patient's consent; (*d*) exceptionally when the doctor believes that disclosure to a third party other than a relative would be in the "best interests of the patient" and when the patient has rejected "every reasonable effort to persuade"; (*e*) when there are statutory requirements to disclose information; (*f*) when a judge or equivalent legal authority directs a doctor to disclose confidential medical information; (*g*) (rarely) when the public interest overrides the duty of confidentiality "such as for example investigation by the police of a grave or very serious crime"; and (*h*) for the purposes of medical research approved by a "recognised ethical committee."[7]

. . . or a "decrepit concept"?

Small wonder, the sceptic may be thinking, that Siegler called medical confidentiality a "decrepit concept." He had looked into the matter after a patient complained that all sorts of people whom he (the patient) had not authorised were looking at his notes. On investigation Dr Siegler was "astonished to learn that at least 25 and possibly as many as 100 health professionals and administrative personnel at our university hospital had access to the patient's record and that all of them had a legitimate need, indeed a professional responsibility, to open and use that chart."[16]

It is too harsh to call the principle of medical confidentiality "decrepit" but it does seem to have lost its way. The problem seems to be that the moral unacceptability of an absolute requirement of medical confidentiality has been recognised by the profession, which has both officially and in practice specified—without explicitly justifying—a set of ad hoc exceptions. On the other hand, doctors in practice (including myself I must confess) are reluctant to give up thinking and talking about confidentiality as though it were an absolute requirement. This reluctance may result partly from a lingering belief that it ought to be absolute and partly from the belief that if patients find out that it is not they will feel aggrieved, even betrayed, and also will stop being honest with their doctors, thus impairing their medical care. If my personal inquiries are representative few non-doctors are aware of how many official and de facto exceptions there are to medical confidentiality. On the other hand, many believe that the supposedly absolute requirement of confidentiality is actually honoured by doctors only in so far as it suits them. If these are typical attitudes doctors' current ambivalence about confidentiality is producing an understandable but undesirable cynicism about their attitudes.

Such cynicism could be reduced—without much if any harm to patient care—by admitting openly that medical confidentiality is not absolute and then justifying,[21] rather than simply stating, the sorts of exception approved by the profession, with a view to achieving a sort of "social contract" between the profession and society about the categories of exception that would and would not be acceptable. If such justification were attempted for each of the GMC's exceptions some would probably be more easily justifiable and more widely acceptable than others. Few people would expect doctors to undertake to disobey (just) laws or facilitate substantial and probable harm to others, yet those possibilities would be entailed by an absolute commitment to medical confidentiality, and it is presumably to combat such an unacceptable commitment that the GMC specified exceptions (*e*), (*f*), and (*g*).

Justification of exceptions

The other exceptions accepted by the GMC seem, however, less easily justifiable and less likely to obtain widespread social approval. Exception (*h*) justifies breaking confidentiality in order to carry out medical research—but ought not patients to be asked before their personal files are used for research? (This could be done routinely on admission or acceptance to a general practitioner's list and the files flagged appropriately.)

Exceptions (*b*), (*c*), and (*d*) are more problematical for they all depend on breaking a patient's confidence on the paternalistic assumption that to do so without consulting the patient will be in the patient's best interests. I have rehearsed the arguments against medical paternalism previously and they seem to be powerful (though I shall consider in a subsequent article certain exceptions such as emergencies, unobtainability of information about the

patient's wishes, and mental incompetence or other causes of sufficiently impaired autonomy). In the normal case, however, I am persuaded that medical paternalism is an unjustifiable anachronism that would receive little if any support in any medicomoral "social contract" and which should be avoided. (Let me reiterate, however, that to object to paternalism is not to object to doctors making decisions if that is what the patient wants—the important thing is to find out what he or she does want.) Nor does there seem much reason to believe that obtaining a patient's consent to disclosure would be excessively difficult "at the sharp" end. ("Good morning Mrs Jones, I've been asked to give you physiotherapy, do you mind if I consult your notes to see what would be best for you?") Few patients are going to refuse what is in their own interests (especially if it is made clear that, as the GMC recommends, any health professional given access to the notes will be bound by the same strong though not absolute standards of confidentiality as are doctors). If patients do refuse certain others access to medical information about themselves, whether it is in the context of (*b*), (*c*), or (*d*), should not their refusal be honoured just as refusal to consult some other doctor or health professional would be honoured? Why not?

An important principle

In summary, medical confidentiality is an important medicomoral principle that can be justified by its contribution to improving people's medical treatment and respecting their autonomy and privacy. It is not, however, an absolute obligation, and this should be made clear. On the other hand, exceptions to medical confidentiality need to be not merely specified, as they are at present, but also justified. Exceptions based on the principles of non-maleficence and justice may well be justified in particular cases, but I have argued against accepting exceptions that are justified by appeals to medical paternalism or the benefits of medical research (both variants of the principle of beneficence which ignore its integral requirement also to respect people's autonomy). In both these sorts of cases patients' permission should generally be obtained if medical information concerning them is to be disclosed to others.

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Medicine and the Media

THE RECENT television presentation by Desmond Wilcox on the saga of the paraplegic PC Olds' fight to walk again (*The Visit: PC Philip Olds*, BBC1, 6, 7, and 8 November) will have been seen by many doctors and many more patients. It is therefore unfortunate that it contained several errors and no reference to work in Britain.

The form of reciprocating walker shown was proclaimed to be a new invention achieved after years of research. Yet I saw this form of device more than 20 years ago, studied intensively by Scrutton in London and McLauren in Toronto. It was eventually abandoned because it imposes a rigidity of control which patients find hard to tolerate, particularly if walking is attempted on anything other than level surfaces. We at the Orthotic Research and Locomotor Assessment Unit came to the same conclusion and have developed two walking devices, one of which allows walking with a reciprocating gait; this is known as the Parawalker (hip guidance orthosis), and a patent was granted in 1976.

We have shown in some 250 paraplegic children and 30 adults that with a rigorous mechanical design and without cables joining one leg to the other they can achieve a high degree of independent walking. We insist, too, that the energy cost is low, and that the patient can independently put on and take off the device and get out of a chair into a walking position.

These results have been achieved through design combined with careful training of orthotist and physiotherapist, and to this end we have established throughout the country eight special centres. We believe it a recipe for disaster in many cases if, as in the case of the walker shown in the programme, component parts are supplied simply on request without the necessary construction and assembly. This can only lead to disappointments.

Having over the past 18 years seen the intense pleasure such devices produce in both patients and relatives we shared to the full PC Olds' evident joy and relief. We are sorry that this has been so long delayed for him because his advisers think that one has to go abroad to achieve success.

I am delighted that at last a campaign to provide independent walking for paraplegics, which I and others have conducted for so long, is gaining in strength and volume. But I think it is important that it is generally understood that the United Kingdom, far from having lagged behind in this respect, has in fact led the world.—G K ROSE, honorary consultant orthopaedic surgeon, Orthotic Research and Locomotor Assessment Unit, Oswestry.

AS PART OF ITS TENTH anniversary activities the charity ACCEPT adopted the imaginative approach of inviting journalists to participate for one day in a programme that has been developed to help dependent and destructive drinkers. The treatment facilities include group therapy, assertive training, transactional analysis, and art therapy.

New clients following the signs to the ACCEPT clinic at the end of Seagrave Road (SW6) go down a long and uninspiring road. On the open day a large wine tanker pumping out a delivery at the rear of an Italian restaurant underscored the scale of UK alcohol consumption—two gallons of pure alcohol per person per year.

The welcoming and relaxed atmosphere at ACCEPT's head-