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HISTORY OF MEDICINE

The Evolution of Confidentiality in the United Kingdom and the West

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By its very nature medical practice involves the opening up of private lives to external scrutiny. The understanding that medical consultations are confidential encourages openness, trust, and frank disclosure of all possibly relevant information between patient and doctor. This in turn facilitates efficient and effective diagnosis, prognosis, and treatment of illness and disease. Confidentiality is therefore an integral element of the patient-doctor relationship, playing a vital role in the primary healing purpose of the profession. As such, it can be considered essential to the moral nature of the practice [1].

However, medicine is not practiced in a vacuum. The boundaries of confidentiality have not been determined solely by the nature of the patient-doctor relationship. Rather, the concept has been affected by a variety of external factors. Historical research into the evolution of approaches to medical confidentiality reveals an enduring ideal that has been interpreted through a variety of theoretical lenses and influenced by more pragmatic concerns.

In terms of theory, the debate has drawn upon consequentialist arguments, deontological ideals of professional duty, and concepts of honor, etiquette, human rights, and bioethics. Specific pragmatic concerns change with the sociohistoric context in which such debates take place, but often incorporate legal constraints, professional interests, health care policy agendas, and the broader sociopolitical environment, including the contested balance between individual liberty and communitarian objectives. What follows is a brief overview of some of these debates and their contexts.

Ancient codes of ethics often implied exceptions to the obligation of confidentiality in general terms. An obvious example is the relevant section within the Hippocratic Oath: “whatever I see or hear in the lives of my patients, whether in connection with my professional practice or not, which ought not to be spoken of outside, I will keep secret, as considering all such things to be private” [2]. While highlighting the long-standing recognition of the importance of confidentiality to medical practice, the qualification that confidentiality covered only those things “that ought not to be spoken of outside” suggests that the obligation of confidentiality was not considered absolute. Over time, and in response to particular concerns, exceptions came to be more specifically defined.

Writing in the late eighteenth century, the British physician and moralist John Gregory noted that doctors, by the nature of their work, had access to the private homes and lives of patients—often seeing them at their most vulnerable. In such circumstances, patients might disclose deeply private thoughts or act in uncharacteristic ways. With this in mind, Gregory emphasized “how much the characters of individuals, and the credit of families, may sometimes depend on the discretion, secrecy, and honor of a physician” [3]. Gregory’s point is echoed in Thomas Percival’s assertion that “secrecy and delicacy when required by particular circumstances, should be strictly observed...The familiar and confidential intercourse, to which the faculty are admitted in their professional visits, should be used with discretion, and with the most scrupulous regard to fidelity and honour” [4].

While the writings of Gregory and Percival, regarded as two of the founding fathers of modern medical ethics, underscore the enduring status of confidentiality as an ethical ideal in medical practice, their emphasis on honor also illustrates how the debate has been shaped by more historically contingent factors. Operating in a competitive private marketplace, elite physicians in eighteenth-century Britain sought to present themselves as honorable gentlemen in order to secure the trust and favor of wealthy upper-class clients.

It was within this context that an elite surgeon challenged the law’s authority to demand evidence from a medical witness during the trial of the Duchess of Kingston for the crime of bigamy in 1776 [5]. The House of Lords, in which the trial took place, rejected the surgeon’s appeal for medical privilege, pointing out that any disclosure of information made at the request of a court of law would not be regarded as contravening the boundaries of professional trust or honor. Detailed analysis suggests that this precedent was set on a false premise, but, despite subsequent challenges, the denial of medical privilege has been maintained in English law [5].

Given its legal basis, attitudes to medical privilege can vary across regional and national jurisdictions—as well as between a single jurisdiction’s civil and criminal law. Although courts of law have recognized the importance of confidentiality to effective medical practice, they have, with few exceptions, routinely ruled that the ends of justice supersede doctors’ obligation of professional secrecy [6]. In most criminal law jurisdictions, judicial rejection of medical privilege has been one area in which exceptions to the rule of confidentiality have become crystallized.

Over the course of the nineteenth and early twentieth centuries, an era of international industrial and military competition, there was a shift from relatively unbridled freedom of the individual in the private medical marketplace to greater emphasis on the collective. This led some doctors to feel pulled between competing obligations to patient confidentiality and collective welfare. As the common law continued to reject calls for medical privilege, statute law and public health policy demands placed new emphasis on the value of medical information beyond its original function in the patient-doctor relationship. In Britain, this emphasis reflected

growing state interest in the health of the population as a key resource to the country's economic and military competitiveness [7].

The emerging specialty of public health brought with it new categories of doctors, such as medical officers of health for municipal authorities, whose agenda reversed the priorities of the private practitioner, rebalancing individual and communitarian interests in favor of collective welfare and "herd protection." Public health legislation required doctors to report cases of contagious and infectious diseases [7]. The rise of public health medicine symbolized the growing importance of a collective health agenda, but medical officers of health were only one example of a growing number of medical roles that emphasized, and began to redefine, physicians' dual obligations to patients and third-party interests. Military physicians, for instance, had an obligation to share information with the chain of command in cases of malingering or when a serviceman posed a risk to himself, his unit, or military objectives [8].

Changes in the organization and funding of health care increasingly meant that private practitioners were drawn into dual loyalty commitments. In Britain, the establishment of the National Health Insurance scheme in 1911, with its associated medical benefits for restricted groups of workers, blurred the surveillance and therapeutic roles of medical practitioners. With workers, employers, and the state all contributing to the cost of health care insurance, each had an interest in the doctor's assessment of an insured patient who sought paid absence from work [9].

Changes within medicine itself also caused problems for the traditional model of medical confidentiality. Growing specialization in medical knowledge and training ensured that, as the twentieth century progressed, patient care was increasingly carried out by combinations of health care specialists and medical institutions rather than an individual doctor. The "patient-doctor" relationship was gradually supplanted by a "patient-health care services" relationship, calling into question the continued relevance of the confidentiality concepts based on the former.

Computers and information technology have facilitated the necessary storage and sharing of patients' information across health care teams but simultaneously raised concerns about data security and accessibility. Changes in the social context of medical practice (not least the entry of women into the medical profession) entail that the eighteenth-century notion of gentlemanly honor stressed by Gregory and Percival no longer figures in debates on medical confidentiality. Instead, current discussions often draw on the discourses of patient rights [10] and bioethics [11], reflecting the contemporary prominence of human rights and the emphasis on patient autonomy in the (post)modern medical world.

The growing recognition and understanding that individual and collective health and welfare are influenced by a variety of social, economic, environmental, and genetic factors points to the importance of collaborative interdisciplinary medical research and integrated, inter-agency approaches to health care policy. The success of such

schemes depends on the correlation of information drawn from an ever-widening range of sources, in a legal context that stresses institutions' responsibilities to ensure that the personal data they hold is not misused. Potential conflicts between, on the one hand, patients' rights to privacy and respect for individuals' autonomy regarding how their personal information is used, and, on the other, the effectiveness of health care policy and medical research, ensure that the boundaries of medical confidentiality continue to pose challenges in the twenty-first century.

It is unlikely that the boundaries of confidentiality were regarded as absolute. Rather, as outlined above, general exceptions to the rule of confidentiality, implied in somewhat vague terms, have become more explicitly defined in response to specific concerns in particular times and places. While research has started to shed light on these historically contingent details, in so doing it has illuminated two enduring features. One is that medical confidentiality has always been regarded as an integral element of good medical practice. The other is that its boundaries have been the subject of perpetual challenge and debate.

References

1. Pellegrino ED. The moral foundations of the patient-physician relationship: the essence of medical ethics. In: Lounsbury DE, Bellamy RF, eds. *Military Medical Ethics*. US Office of the Surgeon General and Department of the Army; 2003:3-21.
http://www.bordeninstitute.army.mil/published_volumes/ethicsVol1/ethicsVo11.html. Accessed August 9, 2012.
2. National Institutes of Health History of Medicine Division. Greek medicine: "I swear by Apollo physician...": Greek medicine from the gods to Galen.
http://www.nlm.nih.gov/hmd/greek/greek_oath.html
3. Gregory J. *Lectures on the Duties and Qualifications of a Physician*. London: W. Strahan; 1772:26.
4. Percival T. *Medical Ethics; or a code of institutes and precepts, adapted to the professional conduct of physicians and surgeons*. Manchester, UK: S. Russell; 1803:390.
5. Ferguson AH. The lasting legacy of a bigamous duchess: the benchmark precedent for medical confidentiality. *Soc Hist Med*. 2006;19(1):37-53.
6. Ferguson AH. Exploring the myth of a Scottish privilege: a comparison of the early development of the law on medical confidentiality in Scotland and England. In: Freeman M, Gordon E, Maglen K, eds. *Medicine, Law and Public Policy in Scotland c.1850-1990*. Dundee, UK: Dundee University Press; 2011:125-140.
7. Ferguson AH. Speaking out about staying silent: an historical examination of medico-legal debates over the boundaries of medical confidentiality. In: Goold I, Kelly C, eds. *Lawyers' Medicine: The Legislature, The Courts & Medical Practice, 1760-2000*. Oxford, UK: Oxford University Press; 2009:99-125.
8. Ferguson AH. Medical confidentiality. In: Carrick D, Gross M, eds. *Military Medical Ethics for the 21st Century*. London: Ashgate Publishing; 2013.

9. Pickstone JV. Production, community and consumption: the political economy of twentieth-century medicine. In: Cooter R, Pickstone JV, eds. *Medicine in the Twentieth Century*. Amsterdam: Harwood Academic Publishers; 2000.
10. British Medical Association. *The Medical Profession & Human Rights: Handbook for a Changing Agenda*. London: Zed Books; 2001.
11. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 5th ed. Oxford: Oxford University Press; 2001.

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