1. The role of history in debates regarding the boundaries of medical confidentiality and privacy.
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The role of history in debates regarding the boundaries of medical confidentiality and privacy.

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Abstract:

Medical confidentiality and privacy are often given a long pedigree as core issues in medical ethics that can be traced back to the Hippocratic Oath. However, it is only recently that focused historical work has begun to examine and analyse in greater detail how the boundaries of medical confidentiality and privacy have evolved within a variety of cultural contexts during the modern period. Such research illustrates the ways in which this process has been shaped by a range of issues, individuals, interest groups, events; and been influenced as much by pragmatic concerns as by theoretical arguments. This paper presents a case for the merits of promoting further historical work on these topics. It suggests that greater support for, and recognition of, historical research has a number of potential benefits. These include providing meaningful context to current interdisciplinary discussions of the collection and use of patient information; improving knowledge and understanding of the foundations on which current policy and practice are built; and promoting public engagement and understanding of the evolution of medical confidentiality and privacy as complex public interest issues.

Introduction.

At its heart, medical practice depends on the transfer of information. Given the particularly personal nature of health information, patients can be reticent about sharing sensitive medical details with friends and family members, and even more so when faced with the comparative strangers encountered as health professionals in hospitals and clinics. The emphasis placed on confidentiality within professional healthcare settings reflects this fact, and aims to facilitate trust and open communication between patients and healthcare workers in order to promote efficient diagnosis and effective treatment of disease and management of illness.

Though medical confidentiality and privacy have long been recognised as integral elements of good medical practice, their boundaries have often been the subject of discussion and debate. Clearly, confidentiality and privacy can be considered important elements of what Pellegrino termed the 'internal morality of medicine,'[1] the ethical principles directly distilled from the primary healing purpose of the relationship between healthcare workers and patients. However, it is equally evident

[1] Edmund D. Pellegrino, 'The Moral Foundations of the Patient-Physician Relationship: The Essence of Medical Ethics', in T.E. Beam and L.R. Sparacino (eds.) *Military Medical Ethics* (Washington D.C.: The Borden Institute, 2003).

that there are times when disclosure of patient information can serve other important interests including public health, medical research, or public safety. Over time, the boundaries of medical confidentiality and privacy have evolved amidst changing attitudes towards the need to consider the balance between competing public interests. This evolution has been shaped by a range of issues, interest groups, individuals and events that have influenced the development of relevant positions in statute and common law, professional regulations, codes of ethics and guidance, and policy and practice initiatives. From a healthcare worker's perspective, the result might appear to be a maze of confusing, if not conflicting, laws, rules, regulations and advice. Certainly, both the General Medical Council and the British Medical Association get more enquiries related to privacy and confidentiality than any other ethical issue.[2]

While, in part, this fact reflects the complex landscape of legal and ethical rules and advice, the uncertainty also stems from the protean nature of the balance of public interests in protecting or breaching patient confidentiality and privacy. Such disclosure decisions are often dependent upon consideration of the specific circumstances of each case, requiring those involved to weigh up a range of factors and exercise a measure of personal and professional judgement. Naturally, opinions can differ, and, over the last two centuries, the boundaries of medical confidentiality and privacy have been the subjects of regularly recurring controversy and disagreement. As such there is a wealth of source material for historians to analyse and draw upon. This ranges from statute laws, legal cases, government files, and minutes of committees within professional bodies and regulators, to journal articles, textbooks and newspapers. In turn, these facilitate a variety of approaches to studying the evolution of medical confidentiality and privacy, including legal, intellectual, social, political and medical histories.[3]

Attempting to engage with this material in a systematic and comprehensive fashion is very time consuming. Understandably, most textbooks on the topic seek to avoid much of the complexity and disagreement that is often uncovered when digging deeper into the historical files. Naturally, a textbook or guidance document, targeted towards giving practical advice to professionals or

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[2] See, in this issue, Fionnula Flannery 'Confidentiality issues in practice: a view from the General Medical Council'; British Medical Association Ethics Department, *Everyday Medical Ethics and Law* (Wiley-Blackwell, 2013), preface.

[3] This reflects methodological approaches to writing the history of many issues in medical law and ethics. See for example, Susan E. Lederer, 'History', in Daniel P. Sulmasy and Jeremy Sugarman (eds.) *Methods in Medical Ethics*, 2nd ed., (Georgetown University Press, 2010), 145-157; Anthony Musson and Chantal Stebbings (eds.), *Making Legal History. Approaches and Methodologies* (Cambridge University Press, 2012); A.C. Hutchinson, *Evolution and the Common Law* (Cambridge University Press, 2005).

patients, seeks to present the reader with as clear a picture as possible. To the extent that such work engages with the past, the focus of interest is typically on noting the final outcome – the decision reached, the policy implemented, the law that was passed – with little time or attention given to investigating the process leading up to that point. Investigation of the latter process usually involves trawling through the minutes of meetings and the correspondence of individuals and committees that took place away from public scrutiny. With limited time and resources, it is unlikely that those writing about the present will consider locating and searching through piles of files of past material.

However, as argued in more detail below, this type of systematic and focused historical work can be useful not only in tracing how we came to be in our current position, but also in more fully appreciating what our current position actually is. It can aid our understanding of how issues have been discussed and decisions made in practice, as an important corollary to abstract normative or theoretical analysis of medical confidentiality and privacy.[4] Building on a growing body of work specifically focused on analysing these issues, this paper examines some of the significant contributions that history can make to interdisciplinary discussions, ranging from the revision of current understandings of relevant legal precedents, through to its role in promoting public engagement with, and understanding of, the complex public interest arguments involving medical confidentiality and privacy. In part, the paper illustrates how detailed historical work can provide an improved narrative of the evolution of medical confidentiality and privacy. It also provides examples of how history can contribute critical analyses of understandings and interpretations of important issues, noting the absence of such historical perspective in past debates, as well as highlighting examples of problems in the current literature.

It must be emphasised that what follows is not intended as a critique of the work of writers from other backgrounds and disciplines for any misunderstandings, or incomplete descriptions of past events. Rather it is a call, to both researchers and funding bodies, for greater recognition of the importance of promoting detailed work on the history of medical confidentiality and privacy, in order that the findings can in future be used by a range of academic disciplines, policymakers, advisory bodies, educators and regulators, to inform ongoing work on relevant issues.

[4] For discussion of the relationship between descriptive and normative ethics see: Daniel P. Sulmasy and Jeremy Sugarman 'The Many Methods of Medical Ethics (Or, Thirteen Ways of Looking at a Blackbird)', in Jermey Sugarman and Daniel P. Sulmasy (eds.), *Methods in Medical Ethics* (Georgetown University Press, 2010), 3-21.

Narrative understanding

Open almost any textbook or article focused on the issues of medical confidentiality and privacy and you are likely to find an early reference to the Hippocratic Oath. Typically, this is used to illustrate the longstanding recognition of the importance of professional obligations of confidentiality owed to patients. Having made this point, most texts then rapidly proceed to discussion of current issues and concerns, with references to relevant legislation, case law, contemporary regulations and guidance. [5]

Giving medical confidentiality a pedigree extending from classical antiquity can serve many purposes, but there is an unfortunate tendency to use reference to the Hippocratic Oath as a convenient, though often vacuous, proxy for discussion of the historical background to current concerns. Recognising that current issues and debates have not materialised out of thin air, citations of the Oath provide a shorthand way of acknowledging that history underpins current approaches, without having to engage in any detailed research, discussion or analysis of it. Even specialised texts on medical confidentiality and privacy, which seek to go further and cite judicial precedent and *obiter dicta* from modern history, typically present a simplistic view of the past – encapsulated in a few lines of quotes treated as established past facts – as a prelude to detailed discussion of the complexities of current problems.[6]

However, as recent historical work emphasises, the stark contrast between these caricatures of a straightforward past that can be readily summarised, and a complex present requiring detailed and lengthy analysis, is both misleading and unhelpful.[7] Beneath the façade of oft-cited precedents and quotes from the past lies a world of discussion, debate and disagreement at least on a par with the most high profile confrontations witnessed today. Drilling down into this historical complexity has a number of benefits. It can promote understanding of how relevant issues have developed over time. It can provide important insights into the process of how decisions have been made and the factors that have influenced them. It facilitates the identification of key themes and recurring points as well as the role played by contingent events. As discussed in later sections of this paper, such historical

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[5] See, for example, William H. Lowrance, *Privacy, Confidentiality and Health Research* (Cambridge University Press, 2012), 52.

[6] See, for example, Jean V. McHale, *Medical Confidentiality and Legal Privilege* (Routledge, 1993 and 2014).

[7] Angus H. Ferguson, *Should a Doctor Tell? The Evolution of Medical Confidentiality in Britain* (Ashgate, 2013); Fairchild, A.L., Bayer, R., Colgrove, J., Wolfe. D., *Searching Eyes. Privacy, the State, and Disease Surveillance in America* (University of California Press, 2007); Andreas-Holger Maehle, 'Protecting Patient Privacy or Serving Public Interests? Challenges to Medical Confidentiality in Imperial Germany', *Social History of Medicine*, 16(3), (2003), 383-401; Andrew A. G. Morrice, 'Should the doctor tell? Medical Secrecy in Early Twentieth-Century Britain', in S. Sturdy (ed) *Medicine, Health and the Public Sphere in Britain 1600-2000* (Routledge, 2002).

analysis promotes a more critical evaluation of the foundations that underpin current approaches to relevant issues. However, it also allows the development of improved understandings of the recent evolution of medical confidentiality and privacy, giving important context to current debates.

The examples used to illustrate points within this paper are drawn from my recent work examining the evolution of medical confidentiality in Britain. Drawing on core themes of continuity and change in the issues, interest groups and arguments that have arisen in discussions of medical confidentiality and privacy over the past two and a half centuries, this work has brought new insight to current understandings. However, in addition to comparing and contrasting issues across time within the same socio-cultural and medico-legal domains, history can bring insights derived from work analysing the comparative evolution in different domains. This might be analysis of approaches under separate medico-legal systems within the same political state, such as differences under English and Scots law within the UK.[8] Or, it might involve comparison of approaches to the same issues as they arise in different nation states.[9] For example, my current work seeks to examine the comparative evolution of medical confidentiality and privacy in a range of Commonwealth countries with elements of shared medico-legal influences but also a variety of socio-political, geographical and cultural differences. Such internationally focused work is of growing significance given the ease of movement of both people and medical data across borders, and the development of international information systems and research networks with global reach.[10]

External, Internal and Administrative Pressures

Recent historical work has begun to shed light on the details of how the boundaries of medical confidentiality and privacy have been shaped by a combination of external, internal and administrative pressures in the recent past. External pressures reflect the fact that the information disclosed and discovered within medical practice has come to be of increasing interest and use beyond the diagnostic and therapeutic context in which it is gathered. In modern society, information has become a valuable commodity to be used and traded for a variety of purposes, and,

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[8] See for example, Angus H. Ferguson, 'Exploring the Myth of a Scottish Privilege: A Comparison of the Early Development of the Law on Medical Confidentiality in Scotland and England', in M. Freeman, E. Gordon and K. Maglen (eds.), *Medicine, Law and Public Policy in Scotland 1850-1980*, (Dundee University Press, Dundee, 2011), 125-140.

[9] Andreas-Holger Maehle and Sebastian Pranghofer, 'Medical confidentiality in the late nineteenth and twentieth centuries: An Anglo-German comparison', *Medizinhistorisches Journal*, 2010, 45, 189-221.

[10] Andrew T. Kenyon and Megan Richardson, 'New Dimensions inprivacy: Communications technologies, media practices and law', in Andrew T. Kenyon and Megan Richardson (eds.), *New Dimensions in in Privacy Law. International and Comparative Perspectives* (Cambridge University Press, 2006), 8-9.

as illustrated below, medical information has not escaped this trend. Internal pressures reflect the fact that medicine itself has changed significantly over the course of the last two centuries, with the development of team approaches to medical diagnosis and care that reflect the shift towards ever greater specialisation in modern scientific medicine. Naturally, this has required the transition from a one-to-one doctor-patient model of medical confidentiality towards a model that extends confidence to a broad variety of healthcare workers who might have input to patient care within modern healthcare systems. Similarly, current medical practice is shaped by medical research, and the latter often depends on the sharing of patient information with researchers who have little or no direct involvement in patient care. In addition, historical analysis has detailed some of the complexities involved in the increasing number of medical roles which appear to have explicit dual loyalty obligations – such as medical officers in the armed forces.[11] Administrative pressures reflect the fact that, in Britain, medicine has transitioned from individuals operating within a highly competitive private marketplace, to a complex leviathan of linked medical institutions and services directly run, or funded, by the central state and involving a vast bureaucratic infrastructure. Inevitably, this has produced challenges in terms of the storage, ownership, and use of patient records and medical files for a variety of clinical, administrative and other purposes. Such challenges have been compounded by the influence of rapid developments in information technology since the latter decades of the twentieth century which have altered the ways in which patient information is collected, stored, linked and shared.

At a basic level, historical work has an important role to play in providing narrative accounts of how these various pressures have shaped the evolution of the boundaries of medical confidentiality and privacy. Such work can provide necessary context to current discussions of developments in these areas. There is not space within this paper to provide examples for them all, but the following illustrates the point in relation to historical work on external pressures.[12]

Medical Privilege

In the eighteenth and nineteenth centuries, most of the external pressure on medical confidentiality came from legal sources, especially from judicial demands that medical witnesses give evidence about patients when required by the courts. Much of the historical work undertaken to date has focused on the issue of medical privilege. As I have argued elsewhere, the common law denial of medical privilege, which would allow doctors to protect communications with patients from

[11] See Angus H. Ferguson, 'Medical Confidentiality in the Military', in M. Gross and D. Carrick (eds.) *Military Medical Ethics for the 21st Century* (Ashgate, 2013), 209-224.
[12] For further examples of external, internal and administrative pressures, see Ferguson, *Should a Doctor Tell?*.

disclosure in court, is based on highly questionable foundations.[13] Due to the need to balance public health goals against the interests of the courts, medical privilege became the subject of extensive debate amongst members of the Ministry of Health, the Law Officers of the Crown and the British Medical Association in the 1920s and 1930s, as well as being a recurring topic of interest at other times.[14] Yet, as illustrated below, in the absence of historical work detailing this narrative, these facts were not widely known by those working on medical confidentiality and privacy a few decades later.

A number of publications in the late 1970s and early 1980s pointed to the growing number, and broad nature, of recognised exceptions to the general rule of medical confidentiality; often questioning whether traditional understandings of medical confidentiality had anything more substantial than rhetorical value by the latter part of the 20th century. In an article exploring some of these issues, one author questioned why, if confidentiality really was so important to medicine, more doctors did not end up in prison for refusing to disclose information about their patients.[15]

Recent historical research on the early interwar years is highly informative on the point, revealing not only that such 'medical matryrs' (as doctors willing to become prisoners in the cause of medical privilege were described at the time) were closer to becoming a reality than previously known, but also that the idea received serious consideration from the Ministry of Health and the British Medical Association, both of which contemplated using medical martyrs as a way to promote their interests. In summary, the problem was as follows.[16] Due to public health concerns over the high incidence of venereal disease in the early twentieth century, a Royal Commission report on the issue recommended setting up state-sponsored clinics for early diagnosis and treatment of anyone concerned they might be infected. In order to encourage people to come forward, the public adverts for the clinics carried a prominent guarantee of confidentiality for patients attending the clinics.

However, immediately following the First World War, there was a sharp rise in the number of cases coming before the civil divorce courts. Providing evidence that a spouse had contracted venereal disease from an adulterous relationship was one way for a petitioner in a divorce case to expedite a decision in their favour, and medical officers from the VD clinics soon found themselves being subpoenaed to give evidence in public courtrooms regarding patients they were alleged to have

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[13] See Angus H. Ferguson, 'The Lasting Legacy of a Bigamous Duchess: the Benchmark Precedent for Medical Confidentiality', *Social History of Medicine*, 2006, 19:1, 37-54.

[14] For details of the interwar discussions see, Angus H. Ferguson, 'Speaking out about staying silent: an historical examination of medico-legal debates over the boundaries of medical confidentiality' in I. Goold and C. Kelly (eds.), *Lawyers' Medicine. The Legislature, The Courts & Medical Practice, 1760-2000* (Hart, 2009), 99-124.

[15] I.E. Thompson, 'The Nature of Confidentiality', *Journal of Medical Ethics*, 1979, 5, 57–64.

[16] For more detailed analysis, see Ferguson, *Should a Doctor Tell?*, chapters 4-6.

diagnosed and treated. Obviously this undermined the prominent assurances of confidential treatment given to the public, but, faced with a mounting backlog of divorce cases, judges insisted that such medical evidence be heard. Naturally, this posed problems for the Ministry of Health, which had taken over responsibility for running the VD clinics in 1919. The Minister for Health made direct appeals to the Lord Chancellor, asking that judges consider the potential damage that would be done to public health if public confidence in the confidentiality of the clinics was undermined, and suggesting that the situation required recognition of a limited form of medical privilege for VD doctors. But such concerns fell on deaf ears. When negotiations appeared to have reached a dead end, the Ministry of Health considered an alternate route to achieving its desired goal.

In early June 1921, John Elliot, medical officer to a VD clinic in Chester, wrote to the Ministry of Health.[17] He had been subpoenaed to appear as a witness in a divorce case and give evidence against a patient. He was keen to know if he had no other choice but to give evidence in the pending trial. In replying, the Ministry explained that, having been subpoenaed, Elliot must attend the court but could protest against being required to disclose confidential information received during his work at the VD treatment centre, making clear that it was in the public interest that such matters remained confidential. If his appeal was not granted, Elliot had two options: have his protest recorded and answer questions; or refuse to give evidence. If he chose the latter, he ran the risk of imprisonment for contempt of court. While being of personal discomfort to Elliot, such an imprisonment would highlight the difficulty of the position that medical officers from VD clinics found themselves in when forced to breach patient confidentiality in court.[18]

Elliot claimed to be of a mind to decline to answer any questions and face the consequences, though he reserved final judgement until he had talked the matter over with his legal counsel. Although he had engaged the services of a lawyer, senior staff in the Ministry thought that Elliot might be persuaded to become a willing martyr in the Ministry's cause of medical privilege. In the course of researching the issue over previous months, the Ministry had come across references to judicial reluctance to force clergymen to disclose information gained in confidence.[19] The suggestion was that judges would not imprison clergymen for refusing to disclose information confided in them, recognising that no form of punishment the court could impose would be sufficient to counter the witnesses' sense of a higher duty. The Ministry now seemed keen to test whether the same leniency would be shown to a doctor who resolutely stood by the principle of medical confidentiality. Elliot

[17] Elliot to Coutts, 3 June 1921, National Archives MH78/253
[18] Coutts to Elliot, 4 June 1921. National Archives MH78/253
[19] Best C J in *Broad v Pitt*, 3 C & P 519; Alderson B in *R v Griffin*, 6 Cox 219.

might provide the test case, if he could be persuaded of the contribution his sacrifice would make to the greater good of the cause.

On 10 June 1921, *The Daily Chronicle* ran two stories relating to the *Needham v Needham* case in which Elliot had been subpoenaed to appear, recounting Elliot's performance in court. The reports noted his prolonged attempt to have medical privilege recognised by the judge, arguing that the 1916 VD Regulations were statutory authority for him not to disclose, and that it was on this understanding that he and others had taken up posts as medical officers at VD clinics. The judge, flatly stated that such regulations held no jurisdiction in the King's courts. Despite further protests that the confidential relationship between doctor and patient was one of the principles held dearest by the medical profession, and that it was essential to public health measures to combat VD, Elliot finally gave in and complied with the judge's order to answer all questions. Although he eventually gave evidence, after entering his protest, Elliot subsequently stated that he would have been willing to go to jail if it had only been for a few days but the risk of imprisonment lasting six months was too great.

In part Elliot's experience in *Needham* begins to answer Thompson's question about why more doctors did not go to prison. In the absence of official support from the Ministry of Health, Elliot was concerned about the negative impact that a prolonged prison sentence would have on his family and medical practice. However, his failure to go to prison did not entail that all was lost. Indeed his prolonged protest in court sparked a reaction amongst colleagues at VD clinics, some of whom wrote to the Ministry of Health threatening resignation unless the Ministry clarified their position. Elliot's experience also provoked a response from the London and Counties Medical Protection Society who felt that 'it may be necessary for some members of our profession to incur martyrdom of the kind with a view to awakening the consciousness of the public'.[20] However, perhaps the most significant response came from the BMA.

The BMA council wrote to the Ministry of Health to say that in light of the ruling in *Needham* they had passed a resolution expressing grave concern about the violation of the public pledge protecting the confidentiality of work at the clinics. The resolution also urged the Ministry to take legislative steps to ensure this wouldn't happen again in future, and requested that the Minister of Health receive a deputation from the BMA Council to discuss the matter. The proposed meeting did not take place. However, it was subsequently reported that a resolution promising the full support of the BMA to any member who refused to disclose information without patient consent, except where it

[20] Woods to Ministry of Health, 20 June 1921, National Archives MH78/253

was already required under statute law, was passed with overwhelming support at the BMA's annual meeting of representatives.

Over the next year, there was something of a tussle between the mass membership of the BMA, who were keen to support medical martyrs, and senior members of the BMA Council and Central Ethical Committee who were concerned that such a policy could significantly dent their limited resources. In the end, a specialist Professional Secrecy Committee was established to consider the matter. The draft report subsequently produced by the Professional Secrecy Committee indicated that, if a policy of supporting martyrs was adopted, then professional support could be made available. The local division would be responsible for successfully maintaining the medical martyr's practice. The BMA would help to organise public opinion through the press and parliament and also provide legal advice and funds for test cases. The report ended on a rather positive note, suggesting that any enforced imprisonment of a doctor would probably be short; the courageous act of going to prison, rather than betraying a patient's confidence, would probably enhance a practitioner's long term prospects, and if any additional funds were needed these could easily be raised by special appeal. Thus, the final paragraph rather looks like a BMA manifesto for the merits of medical martyrdom.

Even in the light of this brief outline, evidently it is overly simplistic to say that the absence of medical martyrs indicates a lack of belief in the value of medical confidentiality. Thompson and others who have queried the absence of medical martyrs were evidently not aware of the case of John Elliot, his contact with the Ministry of Health, and the impact of his courtroom appearance on support for the cause in medical organisations including the BMA. In large part, that is because the case of *Needham v Needham* is not found in textbooks of medical law, or specialist texts on medical confidentiality – indeed the case had largely been overlooked by historians of medicine working on the topic until recently.[21] By contrast, many textbooks cite the case of *Garner v Garner* that took place two years earlier. However, as discussed later in this paper, historical research reveals that many citations of *Garner* are factually inaccurate.

Clearly, detailed historical analysis can help to fill gaps in our understanding of important and recurring issues related to medical confidentiality and privacy. Therefore, even at a basic narrative level, history has significant contributions to make to current understandings. As detailed in the next sections, it also has roles to play in terms of providing critical analysis of existing interpretations.

[21] For a fuller account of the case and its context, see Ferguson, *Should a doctor Tell?*, chapter 4.

Critical analysis of current understandings and interpretations.

As with other ethical issues, it is vitally important to recognise and avoid potential pitfalls when undertaking historical work on medical confidentiality and privacy. As detailed in the early sections of this paper, one is the tendency to use citations of the Hippocratic Oath as a proxy for more detailed analysis of the historical background to current discussions.[22] In addition to this, every effort should be made to avoid both essentialist and presentist approaches. Essentialism, as described by Amundsen, is 'the tendency to see ideas…as free-floating in time and space…to view them metaphysically without reference to any temporal context other than the present, and then, when looking at the culture of any era, to see whatever idea one is examining as essentially the same everywhere and at all times.' [23] Essentialism has obvious appeal for work on issues of medical confidentiality and privacy. The fact that they are regarded as core components of efficient and effective medical practice, and appear to have been long recognised as such, gives them an air of timeless importance. It is undoubtedly possible to consider, in the abstract, the theoretical importance of medical confidentiality and privacy in facilitating the primary healing purpose of healthcare relationships. However, much of the complexity associated with these issues stems from the need to consider how they should be balanced against competing public interests in practice. By looking at how and why decisions have been made in the past, as well as the outcomes of such decisions, historical work can bring practical insights.

Given the high profile of current debates over confidentiality and privacy in relation to health and social care policy, and associated initiatives designed to facilitate a range of objectives including medical research, it is equally important to avoid presentist approaches to historical work.[24] Presentism is 'the natural but naïve tendency to ascribe to earlier periods contemporary values, structures and interpretive categories'[25] – or the failure to recognise that the past typically differs in important ways from the present. There are numerous examples of how historical analysis driven by a presentist agenda can lead to evidence from the past being manipulated to suit current purposes,

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[22] For more on this see Robert B. Baker and Laurence B. McCullough, 'What is the History of Medical Ethics?' in Baker and McCullough (eds), *The Cambridge World History of Medical Ethics* (Cambridge University Press, 2009), 3-15.

[23] Darrel W. Amundsen, 'History' in J.Sugarman and D.P. Sulmasy (eds.) *Methods in Medical Ethics* (Georgetown University Press, 2001), 126-45, 134.

[24] See, for example, Nuffield Council on Bioethics, *Biological and health data. The collection, linking and use of data in biomedical research and health care: ethical issues* (3 February 2015) http://nuffieldbioethics.org/wp-content/uploads/Biological_and_health_data_web.pdf (accessed 10 March 2015); Department of Health, *The Information Governance Review* (March 2013) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192572/2900774_InfoGovernance_accv2.pdf (accessed 10 March 2015).

[25] Amundsen, 'History', 134.

resulting in decisions and approaches based on distorted and inaccurate understandings. Consider the following example from the 1920s, which follows on from the earlier discussion of medical privilege and the Ministry of Health's medical martyr.

Should a Doctor Tell?

In 1922, F.E. Smith, the First Earl of Birkenhead and Lord Chancellor at the time, published an essay entitled 'Should a Doctor Tell?'[26] There are a number of reasons for choosing it as an example of the role of history in debates over medical confidentiality. I will concentrate on two. Firstly, Birkenhead's published essay was incredibly influential in terms of the evolution of the law on medical privilege in the UK. It not only took the wind out of the sails of the Ministry of Health's campaign for medical privilege at the time, but it was also cited by the BMA as a major influence on their decision to put an indefinite hold on proposals to support medical martyrs. Birkenhead's opposition, as set out in his essay, was still being cited as a major obstacle by the proponents of a private member's bill that sought to incorporate a limited form of medical privilege into statute law in 1927, although, by that stage he was no longer Lord Chancellor.[27] The significant momentum behind the drive for medical privilege prior to Birkenhead's intervention was never really regained after it. Yet, for such a significant contribution, it is largely unknown today except by historians specialising in the subject. If the overlooked importance of past works is one reason for choosing Birkenhead's essay, another is that it contains a historical error. As detailed below, closer scrutiny of the text reveals a number of shortcomings in its contents. This includes a liberal editing of common law precedent, to present a continuity of legal opinion that did not actually exist.

Changing the past to fit the present

In July 1921, as the Lord Chancellor's Office gathered 'ammunition' against proposals for medical privilege, Birkenhead's secretary wrote to the office of the Lord Chief Justice. He asked that a briefing paper be prepared which would shed light on the nature of the recognised privilege between lawyers and their clients in connection with legal proceedings and show how this differed from the proposed privilege for medical practitioners.[28] While citing many cases, the resulting brief paid particular attention to the statement given by Lord Chancellor Brougham in the case of *Greenough v Gaskell*.[29] It quoted at length Brougham's assertion that the foundation of the privilege was 'not on account of any particular importance which the law attaches to the business of the legal profession or any particular desire to afford them protection. But it is out of regard to the interests

[26] F.E. Smith, 'Should a Doctor Tell?', *Points of View* (London, 1922), 33-76.
[27] For further details, see Ferguson, *Should a Doctor Tell?*, chapter 7.
[28] National Archives LCO2/624.
[29] *Greenough v Gaskell* [1833] 1MY & K 38.

of justice which cannot be upholden and to the administration of justice which cannot go on without the aid of men skilled in jurisprudence, in the practice of the courts and in those matters affecting the rights and obligations of which form the subject of all judicial proceedings.'[30]

Brougham's words seemed to fit perfectly with the position advocated by Birkenhead. The recognition of the lawyer's privilege was not an effect of judicial favouritism to the legal profession, but rather a necessary element in the process of an equitable justice system. However, a closer look at the details reveals that the author of the brief had been somewhat liberal with the truth in trying to manufacture continuity in legal opinion from the 1830s through to the 1920s. Without giving any indication that Brougham's statement had been edited, the author removed the last section of Brougham's first sentence. According to the original report of *Greenough v Gaskell*, having indicated that the law had no tendency to favour or protect the legal profession, Brougham actually went on to say: 'though certainly it may not be very easy to discover why a like privilege has been refused to others, and especially to medical advisers.'[31]

Clearly the reintegration of these words into Brougham's statement gives an altogether different complexion to his thoughts, than the one presented in the brief given to Birkenhead. For a start, consensus on professional privilege between Brougham and Birkenhead only extended to the legal variety. On medical privilege, the issue in focus and under scrutiny in the 1920s, the two Lord Chancellors had potentially conflicting ideas. So, it appears that staff in the office of the Lord Chief Justice chose to edit out that section of Brougham's statement. When Birkenhead subsequently wrote 'Should a Doctor Tell' and circulated it as a memorandum to all judges and Lords of Appeal, he incorporated, unchanged, this inaccurate version of Brougham's statement. In apparent ignorance of this misrepresentation of fact, Birkenhead went on to state that the common law denial of medical privilege had never seriously been questioned since it was set during the Duchess of Kingston's trial in the late eighteenth century.

Seen in the context of the prolonged, and often heated, debate of the early 1920s, this presents a striking example of how the focus on, and demands of, a presentist agenda can lead to distortions of past events resulting in understandings and arguments based on incomplete or skewed evidence. In the current context it is also worth noting that no one from either the Ministry of Health or the British Medical Association appears to have noticed or questioned the error when the Lord Chancellor circulated and subsequently published the essay. Caught up in the priorities of the present, they spent little, if any, time considering the extent to which there was evidence of support

[30] National Archives LCO2/624. Davies to Birkenhead, undated.
[31] *Greenough v Gaskell* [1833] 1MY & K 38

for their position amongst past judicial opinions and *obiter dicta*. However, as discussed below, such errors are not confined to the past

Revision of Current Understandings

History can provide detailed analysis of important decisions and developments that have shaped the evolution of the law on medical confidentiality and privacy. Though not the primary motivation for undertaking such work, it is possible that at times historical research will uncover details that highlight errors within current interpretations. For example, as mentioned earlier in this paper, the case of *Garner v Garner*[32] is often referenced in current works as an important precedent on medical privilege. The case was a divorce hearing in which a medical officer from a VD clinic was called to give evidence. While he had the consent of his patient to the disclosure, the medical witness believed that the emphasis on confidentiality within the regulations governing the work of the VD clinics entailed that he should not give evidence, and he produced a note from the hospital in which he worked, which echoed this concern.[33] The judge rejected these arguments and the medical evidence was eventually heard.

The case has been cited in many texts as evidence that medical confidentiality can be overridden in court even when the communications to be disclosed are protected by statute law. For example, the latest edition of the influential textbook *Mason and McCall Smith's Law and Medical Ethics* refers to *Garner* to illustrate the absence of medical privilege, stating 'refusal to answer in the absence of the court's discretion to excuse a conscientious witness must expose the doctor to a charge of contempt – and the court will take precedence even when there is a statutory obligation of secrecy.'[34]

However, closer examination of the case reveals that, contrary to popular belief, the guarantee of confidential treatment was not in fact incorporated into statute law. Rather, the importance of ensuring confidentiality was addressed in Article II (2) of the VD Regulations of 1916 which stated that 'all information obtained in regard to any person treated under a scheme approved in pursuance of this article shall be regarded as confidential.' In order to avoid delays in implementing the VD treatment scheme, the Local Government Board did not seek parliamentary support to

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[32] Garner v Garner (1920) 36 TLR 196.

[33] This was contrary to the Ministry of Health's own interpretation of the regulations. For the Ministry, patient consent was sufficient to override the duty of confidentiality.

[34] J.K. Mason and Graeme T. Laurie, *Mason and McCall Smith's Law and Medical Ethics* 9th ed. (Oxford University Press, 2013), 217. For an example of a specialist text on medical confidentiality making a similar claim, see Jean V. McHale, *Medical Confidentiality and Legal Privilege* (Routledge, 2014), 13.

incorporate the VD regulations into statute law.[35] Rather, using powers provided by the Public Health Act 1913, the Local Government Board declared venereal disease a national emergency, allowing it to insist that local authorities adopt the measures for treatment contained in the 1916 VD Regulations.[36] In light of this added detail, it appears that new supporting evidence is required if current interpretations of this aspect of medical law are to be maintained.

Conclusion

Clearly, just as there are a number of approaches to examining the history of medical confidentiality and privacy, utilising a broad variety of source materials, so there are also a number of ways in which such historical research can make significant contributions to ongoing discussions and debates about contemporary policy and practice. The provision of narratives that detail the evolution of the boundaries of confidentiality and privacy amidst external, internal and administrative pressures can fill significant gaps in current knowledge, and add meaningful context to current debates. Examination of the roles played by individuals and interest groups can improve understandings of how recurring issues and arguments have played out in practice and how they have been influenced by cultural factors and contingent events. Drilling down beneath the façade of past policies, statute laws and legal precedents can reveal important insights into their development. At times, such critical analyses will suggest that current interpretations are in need of review, if not revision.

As a result, historical research has roles to play in promoting knowledge and understanding across a broad range of stakeholders within and beyond the academy, from regulators and policymakers working on current issues through to members of the public looking to better understand the policies and laws that underpin how their personal medical information is collected and used. At a time of growing recognition of the importance of ensuring the maintenance of a social licence and public trust for the use of patient information and data beyond the clinic, history can help to promote understanding of how and why the core issues of medical confidentiality and privacy have evolved. Including how they have been balanced against competing public interests over time.[37]

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[35] The Local Government Board implemented and ran the VD clinics until the Ministry of Health took over this responsibility in 1919.

[36] D. Evans, 'Tackling the Hideous Scourge: The Creation of Venereal Disease Treatment Centres in Early Twentieth-Century Britain', *Social History of Medicine*, 1992, 5:3, 413-33, 421-2.

[37] Pam Carter, Graeme T. Laurie and Mary Dixon-Woods, 'The social licence for research: why care.data ran into trouble,' *Journal of Medical Ethics*, 2015. Available online: http://jme.bmj.com/content/early/2015/01/23/medethics-2014-102374.full?sid=3f69c0e4-f181-4e27-98b5-edf23f857d88 (accessed 10 March 2015).

Similarly, historical work can assist healthcare professionals to better understand the complex maze of factors that generate so many questions to the GMC and BMA. Knowledge gained from analysis of the past can help facilitate disclosure decisions in the present.

However, all of this requires more than references to the Hippocratic Oath or quotes from a few lines of statute law or judicial opinions. Detailed historical work takes time and resources, and funding bodies must be willing to provide appropriate grant support to facilitate these outcomes on an ongoing basis. History shows that medical confidentiality and privacy are not amenable to definitive normative analysis, but are perpetually recurring subjects of discussion and debate. Arguably we are currently in the early stages of a new revolution in medicine, in which traditional processes of collecting, sharing and using medically-relevant information are being supplanted by new technologies, including biosensors and smartphones. [38] If we are undergoing a process that may result in the creative destruction of existing medical institutions and practices, with significant implications for medical confidentiality and privacy, it is vitally important to ensure that we understand the historical evolution of these issues. Improved knowledge and understanding of the journey that has brought us to this point will help us to more accurately assess the implications of ongoing developments, weighing up the costs of what may be lost against the benefits of potential gains, and make informed choices about how our personal medical information is collected, stored and used in future.

[38] See, for example, Eric Topol, *The Creative Destruction of Medicine. How the Digital Revolution Will Create Better Health Care* (Basic Books, 2013); Eric Topol, *The Patient Will See You Now: The Future of Medicine is in your Hands* (Basic Books, 2015).