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ARTICLE

Whatever Ought Not To Be Spoken Of Abroad: Formation (of Medical Students) and Information (of Patients)

Al Dowie*

School of Medicine, University of Glasgow, Glasgow

Abstract

Confidentiality has a pre-eminent status in the medical curriculum for ethics, law, and professionalism because it does not depend on prior clinical learning or scientific knowledge, and it provides students with the opportunity to engage in the work of self-formation in professional practice from the very beginning. The historical tendency to romanticise medical professionalism, and confidentiality in particular as a symbol for this, was able to thrive in previous eras as a result of uncertainty around the boundaries of disclosure. To some extent echoes of this romanticism can still be heard today in rhetorical appeals to the Hippocratic tradition despite the development of detailed clarification in frameworks of law, standards, codes, professional regulation, and guidance from the second half of the 20th century.

This paper considers two iconic portrayals of medical professionalism from the romantic period of the Victorian past, contrasting that era with the present-day environment of normative codifications. While ethics is commonly approached in an intellectual mode as a discussion of theory, a purely cognitive understanding is deficient on its own since learning in professional ethics must by definition be reified as sets of practices. The shift to the clinical accountability of today means that practices are of central importance to the undergraduate medical curriculum, not least in the area of confidentiality, for which the General Medical Council guidance sets the UK agenda for medical educational approaches to teaching, learning, and assessment, before students repeat the Hippocratic Oath at graduation as they embark on their future careers as doctors.

Robert Schumann's list of 64 maxims for young musicians ends, poetically, with the observation, 'Es ist des Lernens kein Ende' – there is

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no end to learning.[1] This paper discusses aspects of medical education in relation to confidentiality that students undertake as part of their professional learning, something which by definition also never really ends for the practitioner.

Education in the area of confidentiality is a major component of the undergraduate medical curriculum whereby students engage in the process of becoming tomorrow's doctors, and for this reason it is central to their formation as professionals from the outset. Hence the title of this paper conjoins the educational notion of formative learning with the classical articulation of confidentiality as an ethical imperative in medicine, as found in the Hippocratic tradition, which in one English version reads: 'Whatever, in connection with my professional practice, 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.'[2]

Though the dramatic language of this statement of intent is problematic, as an educational resource for ethics learning the Hippocratic Oath at least offers a starting point for discussion with new medical students on questions around professional allegiance, care of the ill, value of life, personal integrity, as well as confidentiality. It opens up the relationship between the ideal and the practicable. It also invites the contrast between past and present, those things that persist through time, those that are more specific to a particular era, and why this should be so. What it cannot of course provide is a manual for ethical practice, its significance today being that of an historical survival with the function potentially to convey a sense of professional continuity over cultures and epochs.

The ensuing ethics curriculum in the five or so years of undergraduate medicine sets out to address questions that the Hippocratic Oath inevitably begets, and a host of others besides. While antiquity need not go hand in hand with contemporary irrelevance – the influence of Plato, also from the fifth century BCE, suffuses Western thought – the text has little educational utility beyond the entry level starting point, except that it has a tendency suddenly to reappear with symbolic importance at the terminus of the medical student experience, when new doctors are traditionally called to repeat the oath in public during the graduation ceremony. Ironically, the symmetry of returning to this codex at the end of the medical degree might arguably suggest that it subordinates the up-to-date ethics learning they have more recently acquired! Perhaps to counter such a perception, there are revised versions of the oath that some

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1 Robert Schumann, 'House-Rules and Maxims for Young Musicians', in: Konrad Wolff (ed.), Paul Rosenfeld (trans.), *On Music and Musicians* (London: Dennis Dobson 1947), 37.

2 Murray Longmore et al., *Oxford Handbook of Clinical Medicine*, 9th ed. (Oxford: Oxford University Press 2014), 1.

medical schools substitute at graduation, and which are couched in terms more appropriate to modern clinical practice.

While solemnisation through formal declaration is a time-honoured rite of passage for those who are going on to profess medicine, it also opens up the possibility of romanticising such undertakings. Confidentiality as one of the duties of a doctor is typically invoked in public discourse with an almost Platonic connotation, especially by spokespersons of the medical establishment. Daryl Koehn comments on the impulse to make ideological claims to high ethical ideals 'by spokesmen for professions seeking to gain or to preserve status and privilege'.[3] But despite all that medicine can do to benefit the ill, sometimes at best this may only be to interfere with nature rather than to cure; while on the other hand, the commitment not to divulge that which 'ought not to be spoken of abroad' is independent of nature's vagaries. It is thus imbued with a totemic quality for medical professionalism as a whole, despite the discontinuity between its idealised Hippocratic formulation and the empirical realities of practising medicine today, which by contrast are rooted in the mundane. Yet the educational task, rather than being loftily aspirational, is the far more prosaic endeavour to equip medical students for the routine actuality of confidential practice in everyday clinical situations.

At risk of appearing to echo, in a Dickensian vein, Thomas Gradgrind's educational manifesto of 'facts, not fancy', this paper seeks to distinguish the medical school curriculum in confidentiality from its romantic counterpart, which relates not only to the Hippocratic Oath but also to how it is sometimes rendered in arts and culture, not least in film and television representations of doctors and patients. One of the more recent screen creations with a clinical premise is another re-imagining of Arthur Conan Doyle's Sherlock Holmes and Doctor Watson characters, and medical students are as entertained by these dramatisations as viewers are generally, to the occasional misdirection of their developing ideas around the obligations of doctors, and not least in the area of patient confidentiality.

The tension, then, is not between the two cultures of science and art and deciding to favour the objective over subjective moments in medicine,[4] since personal judgement is essential to confidential practice; nor is it the Humean separation of fact and value and choosing to adopt an empiricist stance,[5] since

3 Daryl Koehn, *The Ground of Professional Ethics* (London: Routledge 1994), 2.
4 Charles Percy Snow, *The Two Cultures* (Cambridge: Cambridge University Press 1998).
5 David Hume, 'Sceptical Doubts Concerning the Operations of the Understanding', section 4.1, in: Tom L. Beauchamp (ed.), *An Enquiry Concerning Human Understanding* (Oxford: Clarendon Press 2000), 24.

values are inherent to ethical, legal, and professional norms. Rather, the difference is between popularised versions of the duty of confidentiality and the relevant standards that properly apply to doctors in the clinical setting. This contrast is elaborated below, firstly, with reference to the romantic tradition from the Victorian past in terms of iconic portrayals of medical professionalism; a normative world that would be eclipsed by the development, secondly, of ethical codes in the second half of the 20th century; with these frameworks in turn constituting, thirdly, the basis for the educational pragmatics of confidentiality as a present-day component of students' learning in ethics before they finally take the oath at graduation and embark on their future careers as doctors.

Romanticised Professionalism in Literature and Art: Arthur Conan Doyle and Luke Fildes

The Romantic Movement in the humanities arose in response to the advances in empirical rationality that would in turn lead to the development of scientific medicine from the 19th century, giving rise to an anxiety that has attended the acquisition of new knowledge and its applications since ancient times, such as in the myths of Prometheus and Pandora, and which would find modern expression notably in *Frankenstein*, published in 1818, which Mary Shelley subtitled *The Modern Prometheus*. As well as an anxiety, there was also a mystique surrounding medical practice through the epiphenomena of its diagnostic and therapeutic tools. Although the reality of clinical practice in our time is a long way from that of 'medical men' associated with the period following the Medical Act of 1858 in the UK and with it the establishment of the General Medical Council, the romanticising of medicine would persist well into the 20th century with a legacy that is still present to some extent. However, in the domain of medical confidentiality, the past is indeed another country. The ethical and legal frameworks that have evolved to the present day in the area of medical confidentiality held untested boundaries for clinical practitioners a century and a half ago. In John Rawls' terms, 'If the bases of these claims are unsure, so are the boundaries of men's liberties',[6] and out of this uncertainty a strongly cautious rhetoric around protecting the confidentiality of patients would have been indicated.

In 1887 Arthur Conan Doyle published his first Sherlock Holmes story, written while he was a general practitioner in Southsea, before turning to ophthalmology in London. One motif in these celebrated tales is that of Doctor John Watson (Holmes' chronicler) as a paradigm of protecting confidentiality,

6 John Rawls, *A Theory of Justice*, revised ed. (Oxford: Oxford University Press 1999), 207.

as in that first story when Count von Kramm arrives at 221b Baker Street to engage the services of Holmes, and refers to Doctor Watson as 'a man of honour and discretion, whom I may trust with a matter of the most extreme importance'.[7] In another story, the narrator Watson comments himself in this vein:

'I may say that the writers of agonised letters, who beg that the honour of their families or the reputation of famous forebears may not be touched, have nothing to fear. The discretion and high sense of professional honour which have always distinguished my friend are still at work in the choice of these memoirs, and no confidence will be abused.'[8]

That this is not just a literary trope for Conan Doyle is evident from an address he delivered in 1910 to the medical students of St Mary's, London, at the start of their course, in which he declaims that medical training:

'tinges the whole philosophy of life and furnishes the whole basis of thought. The healthy scepticism which medical training induces, the desire to prove every fact, and only to reason from such proved facts – these are the finest foundations for all thought. And then the moral training to keep a confidence inviolate, to act promptly on a sudden call, to keep your head in critical moments, to be kind and yet strong – where can you, outside medicine, get such a training as that? (...) And then there is another way in which it acts. It sets a very high standard of strenuous work. You may not consider this altogether an advantage while you do it, but it remains a precious heritage for life. To the man who has mastered Grey's Anatomy, life holds no further terrors (...) All work seems easy after the work of a medical education.'[9]

Given the occasion on which he was speaking and the audience seated before him, Conan Doyle may be excused the light-hearted hyperbolic flights of 'the whole philosophy of life', 'the whole basis of thought', 'life holds no further terrors', 'all work seems easy after the work of a medical education', together with the rhetorical emphasis on 'proved facts' that is more in keeping with his fictional creation. Indeed, he prepares us for precisely this style of oratory in his telling choice of title: 'The Romance of Medicine'.

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7 Arthur Conan Doyle, 'A Scandal in Bohemia', in: Iain Pears & Ed Glinert (eds.), *The Adventures of Sherlock Holmes and the Memoirs of Sherlock Holmes* (Harmondsworth: Penguin 2001), 8.

8 Arthur Conan Doyle, 'The Adventure of the Veiled Lodger', in: *Sherlock Holmes: The Complete Illustrated Short Stories* (London: Chancellor Press 1985), 969.

9 Arthur Conan Doyle, 'The Romance of Medicine', in: Robert Darby (ed.), *Round the Red Lamp and Other Medical Writings* (Kansas City: Valancourt Books 2007), 307.

It is natural, then, that he should also embrace confidential practice as part of this romanticised professionalism in his reference to 'the moral training to keep a confidence inviolate'; that is, the formation of character so as to be resolute in not divulging that which ought not to be spoken of abroad. The attribute of inviolability adds a dramatic touch in service of this romanticism, but it also reflects an age in which the comparative lack of legal certainty had the effect of engendering, paradoxically, an exaggerated rectitude in that respect. We know of course from our era there are circumstances where disclosure may not only be appropriate, ethical, and necessary (otherwise it would not be possible to refer patients for investigations or specialist intervention), but that it can also be subject to legal mandate; however, such clarity as we have today on these matters was lacking in the Victorian and Edwardian periods.

The evocative painting by the artist Luke Fildes, entitled *The Doctor* (dated 1887), which hangs in London at the Tate Britain art gallery, though not dealing specifically with the theme of confidential practice, is a vivid representation of romantically stylised medical professionalism from the Victorian era. Its sensibility is expressive of a social realism perspective at the time that sought to interpret the harsh conditions suffered by the poor. The work depicts a privation that is accentuated by the well-dressed gentleman – the eponymous doctor – who is positioned front and centre in the drama, attending with great concern to the care of his young patient.

The tableau portrays the gloomy interior of a rustic cottage. In the shadowed background we see the fearful parents of a sick child, who is laid across two chairs made up as an improvised bed. Sitting at a table, the anguished mother is bent over, her hands clasped as if in pleading desperation, the father's hand resting on her shoulder for comfort. In the foreground, seated, and lit by a table lamp, the doctor has been watching intently over the child through the hours of darkness. At the window, the early rays of dawn softly stream, the break of day symbolising hope.

It is a most affecting scene that, despite the historical distance, will resonate with anyone who has sat up through the night with a desperately ill child, or with someone dearly loved, afraid of what morning may bring. Fildes himself had to bear the sadness of losing his first child, a boy, Philip, ten years earlier. But there is another aspect to this painting. In 1892, a surgeon giving an introductory address to medical students in Leeds at the start of the academic session, entitled 'Doctors in Literature: Old and New', declared:

'But what do we not owe to Mr Fildes for showing to the world the typical doctor, as we would all like him to be shown – an honest man and a gentle man, doing his best to relieve suffering? A library of books written in our honour would not do what this picture has done and will do for the medical profession

in making the hearts of our fellow-men warm to us with confidence and affection.'[10]

Similarly, then, to Conan Doyle's extension of romanticised professionalism to include confidential practice, here the medical establishment naturally makes an explicit extension of Fildes' sentimental rendering to include the relationship of trust and confidence between doctor and patient. Moreover, just as Conan Doyle framed this in terms of dispositional ethics, referring to 'the moral training to keep a confidence inviolate', so also this spokesman for the profession applies a moral reading to *The Doctor* as 'an honest man (...) making the hearts of our fellow-men warm to us with confidence'.

From the moment it was exhibited and gifted to the nation by Sir Henry Tate, the artwork demonstrably functioned as a powerful tool of medical propaganda, and Fildes himself is reported to have said that in this canvas he wanted 'to put on record the status of the doctor in our own time'.[11] Jane Moore describes it as 'a fine example of Victorian spin',[12] since the melodrama not only of an overnight vigil but even of a house call in such lowly circumstances would be an unhistorically devoted picture of medical attention, not least because of the doctor's powerlessness to intervene in a case of overwhelming infection before the era of antibiotic compounds. However, despite its egregious sentimentality, ironically the composition points nevertheless to the nature of an authentic medical professionalism, which is the practice of presence to the ill. In our age where the doctor's gaze in a consulting room is now as likely to be directed to a computer screen during the consultation as it is to the patient, the better to expedite data entry before the next appointment, and the light falling on her or his face from the glow of a monitor – as opposed to the old-fashioned table lamp in the painting – then for all its romanticised contrivance perhaps Fildes' *The Doctor* is still a signifier of something important for medical professionalism today.

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10 W. Mitchell Banks, 'Doctors in Literature: Old and New', *British Medical Journal* no. 1658 (8 October, 1892) 787.

11 'Doctors and Surgeons in Art', *The Times*, 17 March 1959, 13.

12 Jane Moore, 'What Sir Luke Fildes' 1887 Painting *The Doctor* Can Teach Us About the Practice of Medicine Today', *British Journal of General Practice* (2008) 212.

Confidentiality and Ethical Codes

Brazier and Cave make the observation that 'An obligation of confidence to patients lies at the heart of all codes of ethics (...).'[13] The difference between a declaration, a code, a guideline, or a set of regulations is partly in the extent to which their statements, articles, paragraphs, or sections provide explicit detail on what is being pledged or enjoined. Each level of elaboration has its advantages and disadvantages; from highly distilled formulations that say both everything and nothing, to maximally comprehensive delineations that say more than can be readily assimilated, with every additional explication in turn generating further potential complexity.

In its Hippocratic expression, the genre of the oath together with the performative act of repeating it in public during the graduation ceremony is charged with romanticism. This is accentuated by its literary form, which holds the poetic capacity for dramatic promissory statements, as in not divulging what is reckoned to be secret, while also allowing the widest possible scope for interpreting the precise content of those things 'which ought not to be spoken of abroad'. This balance of sensitivity over specificity in the compressed affirmations associated with an oath relies on the appeal to tacit obligations or implications for practice that are conceptually embedded in the exhortation.

This is not quite to attempt the alchemy of transmuting, in David Hume's terms, an 'is' into an 'ought'.[14] But in ethical terms sometimes an indicative can be understood rhetorically to contain an imperative. An example might be the injunction to act our age, or more generally to order our conduct according to our status ('be who you are'). And so with respect to confidentiality, arguably the concept itself entails elements of the obligation that is consequent to it; if one person has knowledge of matters pertaining to another person's life that are by nature private, then this knowledge has the intrinsic property that to be privy to it means categorically (that is, by virtue of the category – the essential nature or necessary quality of confidence) it ought not to be disclosed to a third party, and particularly where obligation is inherent to the circumstances in which it is imparted.[15]

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13 Margaret Brazier & Emma Cave, *Medicine, Patients and the Law*, 5th ed. (London: Penguin Books 2011), 83.

14 David Hume, 'Of Morals', in: David Fate Norton & Mary J. Norton (eds.), *A Treatise of Human Nature*, section 3.1.27 (Oxford: Oxford University Press 2002), 302.

15 *Attorney General v. Guardian Newspapers Ltd* (No. 2) [1988] 3 *All ER* 545 (HL), per Lord Griffiths at 649a.

The challenge for any ethical code is to achieve both intelligibility and utility, which requires of its articles a succinctness combined with minimal ambiguity. For example, at one end of the continuum, the UK Government Office for Science published a universal ethical code for scientists that runs to a mere 153 words, which is at the dimension more associated with an oath; the traditional version of the Hippocratic text cited earlier is more than double the length at 352 words. The responsibility for interpreting any given element of the oath to professional practice then rests upon the individual. At the other end of the continuum, highly specific regulatory manuals have the capacity to delimit the boundaries of proper action to a much greater resolution. Between these points on the scale lies a 'middle axiom' approach, which seeks to specify an intermediate degree of content to underlying principles of ethical practice.

This endeavour is instructively exemplified in the World Medical Association Declaration of Helsinki, which in its 2013 revision is constrained to 2,240 words.[16] The regular process of review has been successful in continually updating and clarifying the text without accumulating an excess of casuistic qualification. The influence of the Declaration of Helsinki is such that its provenance, its readily appropriated level of detail, and sufficiently regular revisions (seven new editions after the original version in 1964) make it an international standard today, acting as a benchmark, for example, for clinical research ethics committees in many countries. In relation to confidentiality, Article 24 of the Declaration affirms that 'Every precaution must be taken to protect the privacy of research subjects and the confidentiality of their personal information.' However, standing between the genres of the oath and more comprehensive regulations, the brevity of its articles – and this is one of the most concise – is again both useful and also a limitation. While explicit on the obligation to take the greatest care in preventing wrongful disclosure in the context of medical research, it is necessarily tacit on the minutiae of compliance with information governance in research, which is a literature of its own.

The precursor to the Helsinki text was the World Medical Association Resolution on Human Experimentation in 1954, which in turn can be seen as a descendant of the Nuremberg Code that was drawn up in 1947 after the war crimes of coercive medical experiments conducted during the Second World War. Though intended to prevent unethical research practices by physicians on human subjects, and placing special importance on obtaining consent, it had little currency among the British medical establishment and it would be

16 World Medical Association: Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects, 7th revision, 2013 (Brazil), www.wma.net/en/30publications/10policies/b3/, 23 July 2015.

another two decades before corresponding shifts in perspective took hold.[17] In the year after the Nuremberg Code was the advent in the UK of the National Health Service (also initially opposed by the medical establishment), following which there would ensue a gradually changing regulatory environment for doctors under the General Medical Council.

A steady proliferation of such frameworks was to follow in the second half of the 20th century. According to Schmidt & Frewer, from their first appearance in 1947 until their audit point in 2000, the total number of international codes on bioethics produced is 326, and the total number of international codes on human experimentation (for example, in the regulation of clinical trials) is 70.[18] The new order of clinical accountability that was being ushered in related not only to ethical standards for biomedicine and medical practice but also to the emerging domain of medical law through the codification of human rights,[19] thereby inaugurating a very different era of professionalism from its romanticised associations in Victorian and Edwardian times. In the UK, the requirements particularly of the General Medical Council in its oversight of undergraduate medical education, its elaboration of the duties of a doctor in *Good Medical Practice*,[20] and its growing corpus of detailed articulations of standards and ethics – especially in the landmark guidance on confidentiality that would be introduced latterly during that general period of clarification – specified criteria of clinical practice that would in turn act as the principal drivers of curriculum provision for student learning in ethics, law, and professionalism in medical schools today.

Education for Confidential Practice

The goal of medical education is for learners to be equipped with the range of relevant competences that are required for their practice as doctors. Following Bloom's taxonomy, in educational terms these competences relate to the three distinct domains of cognitive, psychomotor, and affective learning. For each of these, learning is characterised by a shift, or movement, or change of state occurring within the learner's understanding, of whatever form. In relation to confidentiality in the medical curriculum, clearly there is

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17 Len Doyal & Jeffrey Tobias (eds.), *Informed Consent in Medical Research* (London: BMJ Books 2001), 28.

18 Ulf Schmidt & Andreas Frewer (eds.), *History and Theory of Human Experimentation: The Declaration of Helsinki and Modern Medical Ethics* (Stuttgart: Franz Steiner Verlag 2007), 36.

19 J. Kenyon Mason & Graeme T. Laurie, *Mason and McCall Smith's Law and Medical Ethics*, 9th ed. (Oxford: Oxford University Press 2013), 42.

20 General Medical Council: Good Medical Practice, 2013, www.gmc-uk.org/guidance/good_medical_practice.asp, 23 July 2015.

a substantively cognitive aspect to learning. But purely cognitive acquisition in the areas of ethics, law, and professionalism is deficient on its own. Aristotle recognised that knowledge and reasoning alone were not enough for translating thought into action, stating in *De Anima* that: 'the intellect does not appear to produce movement without desire'.[21] Similarly, David Hume concludes:

'Since morals, therefore, have an influence on the actions and affections, it follows, that they cannot be deriv'd from reason; and that because reason alone, as we have already prov'd, can never have any such influence. (...) Reason of itself is utterly impotent in this particular. The rules of morality, therefore, are not conclusions of our reason.'[22]

Learning in professional ethics has a defining property in that it must primarily be reified as sets of practices. In other educational contexts, ethics is more commonly approached in an entirely intellectual mode as a discussion of theory. However, theory ultimately is not antecedent to practice in relation to ethics. As John Stuart Mill observed, 'what are called first principles, are, in truth, *last* principles (...) Though presented as if all other truths were to be deduced from them, they are the truths which are last arrived at; the result of the last stage of generalization, or of the last and subtlest process of analysis (...).'[23] Theory in ethics derives from the analysis of social practices that are judged to be ethical or otherwise, out of which a systematic account is subsequently constructed.

If education in the area of confidentiality resided purely at the level of theory, then it would not nearly be enough. In medical educational terms, purely cognitive learning ('knowing what') in professional ethics is at the lowest tier of Miller's pyramid of assessment, coming below competence ('knowing how'), then performance ('showing how'), and finally action ('doing').[24] While most of what follows in the remainder of this paper relates to the structuring of intended learning – that is, the framework of teaching in curriculum design – in view of the categories set out by Miller, towards the end some comment will also be in order on the assessment that seeks to promote student learning in this area.

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21 Aristotle, *De Anima: Books II and III (With Passages from Book I)*, III 10 433a22-29, David W. Hamlyn (trans.) (Oxford: Clarendon Press 1993), 69.

22 David Hume, *Treatise*, section 3.1.6, 294.

23 John Stuart Mill, 'On the Definition of Political Economy; and On the Method of Investigation Proper To It', in: John M. Robson (ed.), *Essays on Economics and Society*, vol. IV of *Collected Works of John Stuart Mill* (London: Routledge & Kegan Paul 1967), 311.

24 George E. Miller, 'The Assessment of Clinical Skills/Competence/Performance', *Academic Medicine* 65(9) (1990) (Supplement) S63 et seq.

Confidentiality has two educationally powerful properties that give it pre-eminent status in the medical curriculum for learning in ethics, law, and professionalism. The first property is that it does not depend on any prior clinical learning or scientific knowledge. From the beginning of the course, and based purely on their own life experience, new medical students can relate directly to the idea that information shared with them of a personal nature and not generally known normally carries with it an expectation that it remains private; and conversely that volunteering such information about ourselves is normally done only in circumstances where we can justifiably depend on our privacy being respected. Moreover, the same students will also require little prompting to identify the centrality of trust to the nature of confidentiality, and that such a confidence proceeds on the basis of a relationship between the parties concerned, whether or not they are etymologically aware of the compound in Latin of '*con*' and '*fidere*'.

A further corollary of students' typically adroit insight to these matters without requiring a technical understanding, is that they can readily apprehend the linkage between guarding trust and protecting confidentiality, so that to break a confidence is also to break that relationship of trust. This is of course fundamental to the clinical relationship between doctor and patient, so that in the current edition of *Good Medical Practice* one of the overarching principles specified is that of maintaining trust. But perhaps not so apparent to the new medical student is that the correlation of trust and confidence is much more than a matter of person-to-person ethics, as it relates to the standing of the profession as a whole in the public gaze and before the state. Onora O'Neill, in her discussion of trust in the professions, quotes the following analect of Confucius:

'Confucius told his disciple Tzu-kung that three things are needed for government: weapons, food, and trust. If a ruler can't hold on to all three, he should give up the weapons first and the food next. Trust should be guarded to the end: without trust we cannot stand.'[25]

Referring to the triangle of political forces between the profession, the public, and the state, and the exchange of benefits between these partners, Brian Salter notes that 'public trust in the medical profession is the key to the political arrangement between medicine, society and the state'.[26]

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25 Onora O'Neill, *A Question of Trust: The BBC Reith Lectures 2002* (Cambridge: Cambridge University Press 2002), 3.

26 Brian Salter, 'Who Rules? The New Politics of Medical Regulation', *Social Science & Medicine* 52 (2001) 872.

The second property of confidentiality in the medical curriculum that is profoundly important for student learning is the opportunity to engage in the work of self-formation in professional practice at the very start of the course. From the earliest clinical contact by simply observing medical consultations, or in spending time themselves listening to the narratives of patients, or when learning to take a history of the presenting complaint, students are already embarking on professional learning through the practice – not the theory – of maintaining patient confidentiality. Book knowledge about confidentiality, residing purely in the cognitive domain, is certainly necessary, as our intuitions can only take us so far and in any case cannot assist us with the detail of the legal framework, but is not yet ethical until it becomes experiential learning. Reading 'ethics' strictly in terms of the Greek root '*ethos*' – translated as 'character' or 'habits' – professional learning in confidentiality means above all to learn the habits of confidentiality.

Although students are not registered with the General Medical Council, its guidance on professional practice nevertheless applies to them, so that protecting patient confidentiality is not a theoretical matter prior to becoming qualified practitioners. For example, students have the responsibility not to repeat information outside the clinic or the classroom that could enable another person to identify who a patient might be. The suggestion is not that medical students are necessarily prone to idle chatter about patients, but rather that there is an understandable energy around their experiences of clinical contact, and consequently as part of their learning it is an entirely proper activity to share these with their colleagues. Care therefore needs to be taken that such discussions take place in a context that is compatible with confidential practice. Particularly sensitive is the documentation of any case notes, perhaps for coursework, whether on paper or in computer files, which must be kept safely; and if another person were inappropriately to have sight of these it matters that the names of patients are not stated, or that a reader could not infer someone's identity, or even obtain the date of birth from a Community Health Index number.

Teaching, Learning, and Assessment of Confidential Practice

Teaching, in a generic sense, can be viewed as the larger process undertaken by the educator that, in addition to instructional activities, also extends to designing a curriculum and to the further stages of planning, delivering, and evaluating it. The core content of the curriculum – the subject matter of the discipline – is clearly fundamental to the endeavour of teaching. In the UK, the General Medical Council has oversight of undergraduate medical education, and so its standards and guidance on confidential practice are a

primary source for this part of the curriculum.[27] The GMC website supplements these with learning materials in the form of detailed case studies, the headings for which give a sense of the range of topics in confidentiality that are pertinent to this kind of curriculum: 'Elder abuse – Should a doctor disclose evidence of abuse without the patient's consent?'; 'Serious communicable diseases – Should a doctor override a patient's objection to disclosure of their HIV status?'; 'Sharing information with relatives/carers – Assessing a learning disabled patient's capacity to manage his own care and make important decisions'; 'Alcohol concerns – Should a doctor report concerns about her patient's alcohol consumption?'; 'Reporting concerns about a sex offender – When should doctors report concerns about patients to the police?'; 'Disclosure after death – Should a GP release a deceased patient's medical records?'; 'Reporting the theft of a mobile phone – When can doctors report concerns about patients' criminal behaviour to the police?'

However, for a curriculum to be coherent and meaningful there has to be some sort of design that takes a more structured form than merely the itemising of intended learning; simply to compile a set of outcomes, or a syllabus of topics to be covered, like a smorgasbord of ethically appropriate subjects, is not yet a curriculum design – that is, an intelligible rationale for the overall shape to what is planned and delivered.[28, 29] Whatever design is applied to the process of preparing students for confidential practice, it must display the three essential components of ethics, law, and professionalism as complementary and interdependent sources of norms. These derive from separate but mutually informing discourses, and so bear directly upon each other as frameworks for clinical practice: ethical norms answer to legal requirements and professional standards; legal norms are informed by professional codes and ethical reasoning; and professional norms are subject to the legal minimum and the imperatives of ethical responsibility. They are necessarily woven around each other as intertwined strands, and the analytical function of disassembling them can only be a partial and temporary bracketing of the respective norms.

To take each of these in turn, ethical norms can be understood as criteria for self-directed practice that is not derived from the regulator or the state (though these criteria may or may not coincide), whereby obligation is guided by principles, values, and responsibilities in connection with relevant, ordinate

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27 General Medical Council: Confidentiality, 2009, www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp, 23 July 2015.

28 Steven H. Miles et al., 'Medical Ethics Education: Coming of Age', *Academic Medicine* 64(12) (1989) 707.

29 Al Dowie, 'Making Sense of Ethics and Law in the Medical Curriculum', *Medical Teacher* 33(5) (2011) 384.

interests. Legal norms can be understood as criteria for state-sanctioned practice, whereby obligation is within a formal system of entitlements and duties as specified in the law, which is subject to criteria of ethical and socio-cultural standards. Professional norms can be understood as criteria for validated practice, whereby obligation is according to the academic and clinical standards set by accrediting authorities as both a prior condition and a continuing requirement for licensed practice, and in fulfilment of the supplementary criteria for practising within a specialty and for membership of learned societies such as the Royal Colleges.

The theme of confidentiality is only one subject, albeit one of foremost importance for daily clinical practice, within a broader curriculum strand dealing with capacity, incapacity, consent, equality, human rights, beginning of life, end of life, social responsibility, allocation of resources, and so on. For that reason an overarching curriculum design would be appropriate so as to embrace all of these together with reference to ethical, legal, and professional norms. Within this particular theme, though, in different contexts the emphasis is sometimes on confidentiality, sometimes on data protection, and sometimes on privacy. While there are no hard and fast contradistinctions across these categories, for convenience it is reasonable – in line with the tripartite framework above – to relate confidentiality as a regulatory modality to professional norms, to relate data protection as a statutory modality to legal norms, and to relate privacy as an interpersonal modality to ethical norms.

Beyond matters of structure and content, curriculum design is also concerned with the selection of teaching methods. The age-old lecture remains well-suited to orienting students, raising their awareness, conveying information, and facilitating cognitive acquisition, especially if delivered in an interactive mode rather than purely as an oration. It can also be a relatively inexpensive teaching strategy, and highly serviceable as a digital resource, but has little value for self-formation in confidential practice. Small group formats are more costly, but can be effective in professional learning as a face-to-face context for the reflection that is an essential counterpart to practice. This is particularly so when group sessions can take place in combination with experiential learning in the clinical setting. However, by definition it is not possible to determine in advance the content of clinical experiences, which poses difficulties for specifying learning outcomes.

The experiential focus places the student in the foreground, correlative to the educator's horizon, which is the wider purview of teaching. Learning, by contrast, is what the student does – the way in which the student engages with the curriculum, how the student experiences it, and what constitutes the range of educational activities undertaken by the student. Learning may or may not correspond with curriculum plans, as there will inevitably be occasions where

the formal opportunities provided differ from what was intended; and what is informally delivered (for example, through opportunistic teaching) cannot be determined in advance, as already noted. Moreover, learning includes that other part of the informal curriculum which is not overtly delivered, and known as the hidden curriculum.[30] This includes what the student empirically observes of the actual behaviours of those present in the clinical environment, and is an extremely important type of learning that, again, is outside the ambit of the educator. As Colin Coles comments:

'It is part of the curriculum which was never intended nor became the curriculum in action yet nevertheless it forms a large part of the students' experience (...) It can be much more powerful in determining what students actually do than many teachers or curriculum planners imagine.'[31]

For example, there might be an official hospital protocol for dealing with police enquiries about patients admitted to Accident & Emergency, or responding to members of the extended family seeking information about relatives on a ward, that is at variance with the accepted practice of those members of staff from whom students are likely to take their cue. Far from being passively imitative, it is natural for students to be strongly motivated to form themselves according to what is exemplified by role models in the clinical workplace as an adaptive response to the normative context around them. Given the large proportion of student learning that is represented by the hidden curriculum, the opportunity for exploring these experiences in a small group setting, or reflecting on them in portfolio coursework as a formative assignment, becomes highly significant.

Although such instances of experiential learning are outside the compass of the educator, a useful proxy in the classroom can be to address matters of confidential practice through video resources, for example involving the narratives of real patients talking about situations where the question of disclosure is material – perhaps to their rights, or their employment, or health outcomes for themselves or others. Medical schools also commonly produce videos of varying sophistication to demonstrate clinical consultations, either with real or simulated patients (in role-play). These demonstration videos might be exemplars of good practice or otherwise, or intended as prompts for discussion, or designed as 'virtual patients' in interactive educational software where the video clip is linked to a series of text-based choices that lead to further decisional

30 Benson R. Snyder, *The Hidden Curriculum* (New York: Alfred A. Knopf 1971).
31 Colin Coles, 'How Students Learn: The Process of Learning', in: Brian Jolly & Lesley H. Rees (eds.), *Medical Education in the Millennium* (Oxford: Oxford University Press 1998), 66.

nodes, which at the end point automatically generates feedback for the student according to the path traced by those responses. While clearly at a remove from students' own competence in the psychomotor domain, any approach centred visually on authentic, concrete action rather than wholly abstracted from it is at least oriented to the practice of confidentiality, even though residing in the cognitive domain (and potentially engaging with the affective domain).

Assessment, on the other hand, does afford possibilities for activating students' psychomotor competences. At a cognitive level, though, written exams are of course essential for assessing the extremely important knowledge base concerning the ethical, legal, and professional frameworks for confidential practice that students must acquire. In this connection, an example of the 'modified essay' type of question would be as follows:

'(a) State three general categories of clinical situation in which disclosure of patient information can be justified without obtaining consent. (b) Illustrate each of these general categories with one example. (c) Using one of the examples you provided, outline the General Medical Council guidance on best practice in that clinical situation and explain the reasoning behind it.'

Alternatively, an example of the 'short note' type of question would be as follows:

'A patient attending your hospital clinic insists that he does not wish his general practitioner to be informed of his diagnosis. Briefly summarise your ethical, legal, and professional responsibilities in this situation.'

Clinical exams, by contrast, are practical assessments in a psychomotor mode that function at the level of performance. The Objective Structured Clinical Examination (OSCE) presents the student with a sequence of separate clinical tasks that are performed in different rooms, each with its own examiners observing and assessing each student individually in strict rotation. The student does not know in advance which precise tasks will be set. There is a fixed time allowed for these across all the stations, perhaps as little as five minutes, after which the signal is given for the student to leave the room and move on to the next task in another room, which has just been vacated by another student, while the examiners complete a pre-formulated marking schedule on the student who has just been seen. Some of these OSCE tasks will involve the student conducting a simulated physical examination of a surrogate in the room who is playing the role of a patient. Other stations will be simulated clinical consultations in like fashion, which among other things provides useful opportunities to assess the student's performance in relation to confidentiality. An example of such a task in this type of OSCE station would be as follows:

'Mrs Lee and her 15-year-old daughter Jenny are both patients of yours in general practice. Today Mrs Lee has an appointment on her own to see you in order to discuss the oral contraceptive prescription that you issued to her daughter, and which Mrs Lee was upset to find hidden away in Jenny's bedroom. You have five minutes to respond to Mrs Lee's concerns.'

However, an OSCE station can only test performance of a set task, which in terms of Miller's categories noted earlier is not yet at the level of action. In other words, there is a distinction between students' performance in an examination context and their practice in situ. For that, a workplace assessment is required, for example a report on how a student is responding practically to the obligations of patient confidentiality, or through observation in the clinical setting, or 360-degree multi-source feedback collated from a range of colleagues in the workplace.

Summary and Conclusion

This paper has argued that the historical tendency to romanticise medical professionalism in general, and the symbolic appeal to confidentiality in particular, were able to thrive in previous eras as a result of uncertainty around the boundaries of disclosure. To some extent echoes of this romanticism can still be heard in rhetorical discourse despite the development of detailed clarification in frameworks of law, standards, codes, professional regulation, and guidance from the second half of the 20th century. This shift to the clinical accountability of today means that practices are of central importance to the undergraduate medical curriculum, not least in the area of confidentiality, and these sources now set the agenda for medical educational approaches to teaching, learning, and assessment that seek to prepare students for confidential practice in the present.

At the end of the medical degree, students will repeat the oath during the graduation ceremony linking them to the ancient promise not to divulge 'that which ought not to be spoken of abroad', which of all the specific pledges is the one that the Hippocratic tradition places at the end. Yet this very last undertaking – that they will own confidential practice – which in a sense is their final learning activity before leaving university, will have been one of the first steps in professional learning taken by those students at the beginning of their studies.

To echo Robert Schumann, there is of course no end to professional learning, those incremental shifts that constitute a training – the figure being a horticultural one, an organic drawing along and fostering of growth in a specified direction. Training is not a passive activity of 'being formed', but an interplay

of following and intending, of learners taking the opportunities available to develop themselves professionally, which starts with the self-formation of medical students and the personal information of patients.