However, were the judge to allow the plaintiff to argue his case on the basis merely of risk of identification, the door would be open to argument about the degree of risk that the patient might be identified as a result of reading the report. Hence such matters as the nature and extent of the readership of the publication, and its availability, would be relevant.

Professor Dimond also asserts, ambiguously, that "any attempts to justify disclosure on the basis of public interest would not be supported by the decision in W. *v.* Egdell". That case, however, concerned circumstances of an entirely different character and is of doubtful relevance to the issue under discussion. It seems far from certain that a judge, in a case in which reasonable care had been taken to anonymise the personal details in a case report published in a professional journal and read almost exclusively by other professionals in the field, in which there was no wanton or gratuitous disclosure of personal information such as would enable the generality of readers to identify the individual concerned, and in which it could be argued that there was a scientific value to the publication, which would be eroded by further distortion and falsification of the personal information provided, might not rule publication justified in the public interest.

Even were such an action to succeed, the damages would probably be nugatory.

It is entirely reasonable for authors to discuss proposed case reports with the patient concerned, if the patient's condition is such that he is able to engage in a sensible conversation on the matter, but the requirement that consent be obtained from the patient in every instance is absurdly over-sensitive and, as Professor Russell, Dr Healey and Professor Marks all point out in the same editorial, likely to inhibit publication of potentially valuable reports.

Many millions of case reports must have been published in the medical literature without, so far as I am aware, a single action for breach of confidence having followed. Certainly Professor Dimond quotes none. May I suggest a second opinion?

WILKINSON, G., FAHY, T., RUSSELL, G., *et al* (1995) Case reports and confidentiality. *British Journal of Psychiatry*, **166**, 555–558.

I. G. BRONKS

27 Friar Gate
Derby DE1 1BY

AUTHOR'S REPLY: The subject of the law on confidentiality is complex and I am sorry that my attempts to simplify were regarded as superficial. My short paper arose from a request by a psychiatrist who had published a case study which had been recognised by the subject of the case study (a doctor). Identification (by changing personal details) had not been prevented on the grounds that if details were changed, then case studies could not be compared for the purposes of medical education. Nor had the patient's consent been obtained to the publication. The question I was asked was "Is this a breach of confidentiality?" My response was "yes".

Difficulties arise from a lack of decided cases of statute provision and also from the fact that the duty arises from several sources.

1. If the action of the patient is based on the duty of care owed in the law of negligence, then harm must be established for the action to succeed and in that case, compensation might be negligible. In such a case it would have to be established that another person recognised the patient's identity, since that would be how harm occurred. A case where this action was recognised is the New Zealand case of Fitchett *v.* Furness (1958). Dr Bronks appears to be concerned only with this right of action.

2. There has been recognition in a recent case (1988) that there is a legal duty to keep information which has been passed on in confidence, confidential, even when there is no pre-existing relationship or legally enforceable contract between the parties. This arises from the law of equity. An injunction would be obtainable to prevent a disclosure which was in breach of this duty (Mason & McCall Smith, 1967).

3. There is also a professional duty, recognised by most Codes of Professional Practice and Ethics, to keep confidential information about the patient unless consent is given to the disclosure by the patient or there is a recognised legal duty to disclose. Here, unlike the law of negligence, the misconduct lies in the disclosure rather than in any harm which could or has occurred. A report to the registration body about a breach of the Code of Professional Practice and Ethics may also be possible (Finch, 1994), and could result in the practitioner's suspension or erasure from the Register.

4. In addition there may be a term in the contract of employment for employees to keep confidential, information about a patient (subject to recognised exceptions). This duty is enforceable by the employer through disciplinary proceedings and thus the hospital or employed doctor is in a different situation than the self-employed practitioner. This contractual duty exists irrespective of any harm which occurs.

I then explored the possibility that publication of a case study from which the patient could be identified was justified under one of the recognised

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exceptions to the duty of confidentiality. The only exception which appeared relevant appeared to be the public interest. As I pointed out, and Dr Bronks agreed, the case of W. *v.* Edgell covered very different facts and would not be a valid authority. Other cases on disclosure in the public interest do not cover the issue.

Dr Bronks is mistaken in assuming that I wish to end the practice of case studies being written. I am suggesting that the patient's consent is obtained or identification made impossible. He does not state in how many of the published case studies consent was obtained or identification prevented. Because of the need for clarification in law, the Royal Colleges, professional bodies and numerous health professional associations have drafted a Bill Governing the Use and Disclosure of Personal Health Information (1994). This Bill envisages that the patient should consent to the use of identifiable information as part of training in medicine, nursing or other health care.

It should be realised that there are many other health professionals apart from doctors who write up case studies of patients. I would suggest that the same principles on confidentiality should apply to them all.

BRITISH MEDICAL ASSOCIATION (1994) Draft Bill Governing the Use and Disclosure of Personal Health Information.

FINCH, J. (1994) *Speller's Law Relating to Hospitals* (7th edn). London: Chapman & Hall.

Fitchett v. Furness (1995) *New Zealand Law Report*, **396**.

MASON, J. K. & MCCALL SMITH, R. A. (1967) *Law and Medical Ethics* (2nd edn), p. 136. Citing the case of Duchess of Argyll *v* Duke of Argyll (1967) Ch. 302. 1965, 1 All ER611 and authorities in text books. Butterworths.

Stephens v. Avery and others (1988) 2 All ER477.

B. DIMOND

16 Highfields
Llandaff
Cardiff CF5 2QA

A HUNDRED YEARS AGO

"The Association of Workers in Asylums for the Insane."

To the Editors of THE LANCET

SIRS,—I notice in THE LANCET of July 27th, under the above heading, that a meeting has been held at which Sir B. W. Richardson delivered an address. He is reported to have said that "education and training raised the status and increased the usefulness of nurses, and this experience will no doubt be repeated when the same conditions are applied to attendants on the insane." I cannot allow such a statement as this to pass unchallenged. For many years past the attendants and nurses on the insane have been carefully educated and trained. After a period of two years, during which the attendants and nurses have to attend a dozen lectures and the same number of clinical demonstrations in the wards of a hospital for the insane, they are examined, and, if successful, are granted a certificate of proficiency in nursing the insane. The superintendent of the hospital trains his attendants and nurses, but he has nothing to do with their examination. The written portion is conducted by examiners appointed by the Medico-Psychological Association of Great Britain and Ireland, and the clinical and *vivâ voce* part by an examiner who is generally the superintendent of a neighbouring asylum. The severity of the examination is shown by the fact that at every examination a number of candidates are plucked. The result of the education, training, and examination has been to increase the usefulness of the nurses and attendants, who now take a more intelligent interest in the cases under their care; while, as regards their status, it is quite on a par with hospital trained nurses. Indeed, some of the latter are anxious to obtain the certificate, and a scheme is on foot for admitting them to the examination after a definite period of training. Altogether more than 1000 nurses and attendants possess the certificate which is granted by the Medico-Psychological Association of Great Britain and Ireland.

I am, Sirs, yours faithfully,

FLETCHER BEACH,
Honorary General Secretary, Medico-Psychological Association of Great Britain and Ireland.
Welbeck-street, W., July 30th, 1895.

Reference

Lancet, 3 August 1895, 281.

Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey

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