

Ferguson, Angus H. (2005) *Should a doctor tell? : medical confidentiality in interwar England and Scotland.*

PhD thesis

<http://theses.gla.ac.uk/3150/>

Copyright and moral rights for this thesis are retained by the author

A copy can be downloaded for personal non-commercial research or study, without prior permission or charge

This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the Author

The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the Author

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given

Should a Doctor Tell?
Medical Confidentiality in Interwar England and Scotland

By
Angus H Ferguson

Centre for the History of Medicine
Department of Economic and Social History

Faculty of Social Sciences
University of Glasgow

Submitted for the Degree of
Doctor of Philosophy

February 2005

© Angus Ferguson, 2005

Abstract

Medical confidentiality is integral to the doctor – patient relationship and an important element in efficient and effective medical practice. However, it is generally acknowledged that medical confidentiality can not be absolute. At times it must be broken in order to serve a ‘higher’ interest – be it public health or the legal justice system. Yet, very little is known about the historical evolution of the boundaries of medical confidentiality in Britain. The absence of detailed historical research on the subject has meant that contemporary writers have tended to use citations of the Hippocratic Oath or short quotations from key legal cases to place their work into longer term context. The current thesis provides a more detailed examination of the delineation of the boundaries of medical confidentiality during a period of intense debate - the interwar years of the twentieth century. The increase in state interest in the health of the population, the growth in divorce after the First World War and the prominence of the medical issues of venereal disease and abortion, all brought unprecedented challenges to the traditional concept of medical confidentiality. Having examined the, oft-cited, benchmark precedent for medical confidentiality from the late eighteenth century, the thesis proceeds to examine the ways in which medicine had changed by the interwar years. The high-point of the debate in the early 1920s is examined from the perspective of the three key interest groups – the Ministry of Health, the British Medical Association and the Lord Chancellor. Overall, the work provides insight into the historical delineation of medical confidentiality in Britain, both in statute and common law. As such it lends a longer-term context to current debates over the boundaries of medical confidentiality in the twenty-first century.

Table of Contents

	Page
Abstract	2
Acknowledgements	4
List of Abbreviations	5
Chapter 1 – Introduction	6
Chapter 2 – The Duchess of Kingston’s Trial	16
Chapter 3 – The Long Nineteenth Century	36
Chapter 4 – The Ministry of Health	71
Chapter 5 – The British Medical Association	96
Chapter 6 – The Lord Chancellor	138
Chapter 7 – The Attempts to Pass Legislation	154
Chapter 8 – The Varied Context of Medical Confidentiality	190
Chapter 9 – Conclusion	225
Bibliography	235

Acknowledgements

I thank my supervisors, Professor Anne Crowther and Dr Marguerite Dupree, for their continued interest, guidance and support during the preparation of this thesis. Along with the staff and students of the Centre for the History of Medicine, they have made the process an enjoyable as well as a rewarding one. The staff at the University of Glasgow Library and Special Collections, and the National Archives, Kew have been very helpful. The thesis has drawn heavily on the archives of the British Medical Association held at Tavistock House, London, and I am grateful to their Information Officer, Lee Sands, for his assistance during research trips there. The work was made possible through PhD funding from the Economic and Social Research Council. The continuing support of my family has been greatly appreciated.

List of Commonly Used Abbreviations

BMA	British Medical Association
<i>BMJ</i>	British Medical Journal
CEC	Central Ethical Committee (of the British Medical Association)
Council	The Council of the British Medical Association
Ministry	Ministry of Health
VD	Venereal Disease

Chapter 1 –Introduction

The doctor's consulting-room should be as sacrosanct as the priest's confessional. The whole of the art and science of medicine is based on the intimate personal relationship between patient and doctor, and to this it always returns, however scientific medicine becomes and whatever the great and undeniable benefits society receives from the application of social and preventive medicine.¹

Confidentiality is the cornerstone of the doctor-patient relationship. From the citation of its importance in the Hippocratic Oath to its prominence in discussions about ethics in twenty-first century medicine, successive generations have acknowledged that medical confidentiality must be protected.² Yet, for a concept regarded as integral to medical practice, very little is known about the historical development of medical confidentiality in Britain. Writers tend to point to the Hippocratic Oath or the lines of a few judicial rulings in order to place current challenges to medical confidentiality into some historical context.³ In the absence of detailed research on the more recent history of medical confidentiality, contemporary accounts give the impression that, until recently, medical confidentiality has been a relatively unchallenged feature of medical practice. It is the aim of this thesis to bring a more accurate historical perspective to the debates over medical confidentiality by examining its development during the interwar period of the twentieth century.

The interwar years provide a useful period of analysis because of the unprecedented challenges that medical confidentiality faced at that time. The emphasis on the individual patient in the traditional doctor-patient relationship came under increasing pressure from a rising concern about the health of the population as a whole. The growth of state interest in the health of the population from the late nineteenth century was heightened by the circumstances of the First World War.

¹ H A Clegg, 'Professional Ethics', in M Davidson (ed), *Medical Ethics. A Guide to Students and Practitioners* (London, 1957), 44.

² R Gillon, *Philosophical Medical Ethics* (Chichester, 1996), 106.

³ A key example of this can be found in J V McHale, *Medical Confidentiality and Legal Privilege*, (London, 1993), 13. For a discussion of confidentiality with regard to HIV / AIDS see A Campbell et al., *Medical Ethics* (Oxford, 1999), 115-117; for a discussion of confidentiality and the Human Genome Project see I J Brown and P Gannon, 'Confidentiality and the Human Genome Project: A Prophecy for Conflict?' in S A M McLean (ed) *Contemporary Issues in Law, Medicine and Ethics* (Dartmouth, 1996).

Britain needed not only a healthy workforce but an effective armed force. The state targeted medical issues of particular concern – doctors had a statutory duty to notify the local authorities about cases of infectious disease or illegal abortions. Venereal disease (VD) was widespread and a national policy for combating it was developed in 1916, including a well advertised pledge that all treatment would be strictly confidential. Societal changes placed demands on medical information too, with a sharp rise in the number of divorce cases putting further pressure on doctors whose testimony was often required.⁴ Aldous Huxley's *Brave New World*, regarded by the present day media as the model against which to measure society's move towards factory-style medicine concerned with the collective rather than the individual, was written during the early 1930s and, along with many other dystopian novels, reflected a concern over the loss of individual liberty in the drive for state control and the primacy of collective interest – a drive from which medicine was by no means exempt.⁵

The State is beginning to assert its regulative powers in departments of social and even family life from which hitherto it has held aloof, and its justification will always be that the interests of public health override the personal interest of the individual.... We may expect sharp controversy, for example, if and when the State concerns itself directly with eugenics, and asserts its solicitude for a generation not yet born, not by the creation of cradles and nurseries, but even by the very determination of parentage itself.⁶

In recent years, work looking specifically at the history of medical ethics has begun to shed light on the development of the subject in Britain. The advent of modern day medical ethics is generally traced back to the late eighteenth century and the writings of John Gregory and Thomas Percival. Regarded as the founding fathers, these writers have received much attention. Laurence McCullough makes a strong argument for seeing Gregory's work as an early instance of what today is termed 'bioethics'.⁷ The

⁴ R Phillips, *Putting Asunder. A History of Divorce in Western Society* (Cambridge, 1988), 516-517.

⁵ A Huxley, *Brave New World* (London, 1994); E Zamiatan, 'We' in B G Guerney (ed) *An Anthology of Russian Literature* (New York, 1960), 163-353; G Orwell, *Nineteen Eighty-Four* (London, 1989).

⁶ Robert George Hogarth's presidential address to the BMA as cited in the *BMJ* 1926 vol.2, 146.

⁷ L B McCullough, 'Laying Medicine Open: Understanding Major Turning Points in the History of Medical Ethics' in *Kennedy Institute of Ethics Journal*, 9, (1999), 7-23; L B McCullough, 'Virtues, Etiquette, and Anglo-American Medical Ethics in the Eighteenth and Nineteenth Centuries' in E Shelp

basis of Gregory's arguments within a philosophical framework – namely the Humean concept of sympathy – and his stress on the importance of the patient (medicine being emphasised as a fiduciary profession) bear obvious similarity to twentieth century bioethics. By contrast, Percival's work has often been construed as little more than a treatise on medical etiquette with scant bearing on ethics as defined in the modern day sense. This criticism has been refuted by later writers who point to Percival's emphasis on the doctor's duty to society as an example of ethics.⁸

However, while Gregory and Percival had a significant impact on the development of codes of ethics in America, culminating in the American Medical Association's code of ethics in 1848, no such code was adopted in Britain despite attempts by Jukes Styrup, a Shrewsbury practitioner with an established interest in medical ethics, to have his code adopted by the British Medical Association.⁹ Rather, as Crowther has pointed out, doctors found guidance on medical ethics within the legal framework, mainly in textbooks of medical jurisprudence.¹⁰ Thus when Styrup tackled the question of confidentiality in his code, the importance of legal precedent was evident

The obligation of secrecy extends beyond the period of professional services; - none of the privacies of personal and domestic life, no infirmity of disposition or defect of character observed during professional attendance, should ever be disclosed by the medical adviser, unless imperatively required. The force and necessity of this obligation are indeed so great, that professional men have, under certain circumstances, been protected in their observance of secrecy by courts of justice.¹¹

(ed) *Virtue and Medicine* (D Reidel Publishing, 1985), 81-92; L B McCullough, 'John Gregory (1724-1773) and the Invention of Professional Relationships in Medicine', *The Journal of Clinical Ethics*, 8, (1997), 11-21; L B McCullough, *John Gregory and the Invention of Professional Medical Ethics and the Profession Medicine*, (Dordrecht, 1998).

⁸ For a concise analysis of the debate see Robert Baker's introductory chapter in R Baker (ed), *The Codification of Medical Morality* vol.2 (Dordrecht, 1995), 1-22.

⁹ P Bartrip, 'An Introduction to Jukes Styrup's A Code of Medical Ethics (1878)', in R Baker (ed), *The Codification of Medical Morality* vol.2 (Dordrecht, 1995), 145-148.

¹⁰ M A Crowther, 'Forensic Medicine and Medical Ethics in Nineteenth-Century Britain' in R Baker (ed), *The Codification of Medical Morality* vol.2. (Dordrecht, 1995), 173-190.

¹¹ J Styrup, 'A Code of Medical Ethics', in R Baker (ed), *The Codification of Medical Morality*, vol.2 (Dordrecht, 1995), 150.

One of the key implications of the basing of medical ethics in a legal framework was that medical confidentiality was discussed in legal rather than philosophical terms. Members of the medical profession often referred to honour and duty in connection with the medical tradition – Styrap's code stated 'the familiar and confidential intercourse to which a "doctor" is admitted in his professional visits, should be used with discretion, and with the most scrupulous regard to fidelity and honour'¹². But this generally referred to the social ideal of an upper-class gentleman and relevant philosophical terms like 'deontology' were never included in such accounts. Similarly the Ministry of Health's concern with public health led it to judge the merits of keeping or breaching medical confidentiality based on the consequences for society rather than for the individual patient. However, they did not use philosophical terms like utilitarianism or even the more generic consequentialism. Reflecting the historical position, the main focus of what follows is the interaction between medicine and the law over the boundaries of medical confidentiality.

With the law's centrality to the debate, a significant distinction must be drawn between medical confidentiality outside and within the course of legal proceedings. The general recognition that the doctor-patient relationship has an implied measure of confidentiality does not extend to a claim of privileged communications which would enable such information to be withheld from legal proceedings in a court of law. The issue of medical privilege is an important one. There are two forms of privilege. Statements made within the course of legal proceedings are considered privileged in so far as a doctor (or any witness) cannot be sued for giving relevant and accurate information in the witness box. The second form of privilege is a claim that certain information which is required during legal proceedings was obtained in circumstances which do not permit its disclosure. It is this latter form of privilege which was the subject of much of the debate described in this thesis. A central aim of the current work is to shed light on the historical reasons for the absence of medical privilege (in the latter of the two senses) in Britain in contrast to certain other European and Commonwealth countries and American states by looking in greater detail at some influential legal precedents.¹³ It must be stressed that key legal precedents will be set back into their historical context in order to obtain a greater perspective on the

¹² P Bartrip, 'An Introduction to Jukes Styrap's A Code of Medical Ethics (1878)', 150.

¹³ For a list of European countries that developed statutory protection for medical confidentiality see A H Maehle, 'Protecting Patient Privacy or Serving Public Interests? Challenges to Medical Confidentiality in Imperial Germany', in *Social History of Medicine*, 16, (2003), 383-401.

significance of their short and long-term impact on medical confidentiality. Trials, particularly high profile trials, have a considerable element of theatre to them which is lost to the reader who is given a few lines of judicial ruling extracted from the context of the case as precedent.¹⁴ In this respect, it follows the example set by Angus McLaren in his examination of the celebrated trial of *Kitson v Playfair*, 1896.¹⁵

Linda Kitson was the wife of Arthur, a 'ne'er-do-well' who was the youngest son of a wealthy Leeds iron founder. The couple met and married in Australia in 1881. In 1892 Linda Kitson returned to England while her husband, pursued by creditors, stayed abroad. Shortly after her arrival, Arthur's two elder brothers decided that she should receive the £500 annual allowance that had previously been sent to her husband. Suffering poor health, Linda Kitson consulted Dr Muzio Williams who suspected some form of obstetrical problem. Arthur's sister had married Dr William Smoult Playfair 'perhaps the best known obstetrician in Britain' and royal accoucheur. Williams suggested that Linda Kitson should consult her brother-in-law, which she reluctantly consented to do in early 1894. During the medical examination, Playfair and Williams found evidence of a recent miscarriage or abortion. As she had left her husband in Australia almost a year and a half previously, Playfair concluded that she must have had an affair. With nothing to confirm Linda Kitson's suggestions that her husband had secretly been in London and had caused the pregnancy, Playfair felt bound to inform his wife of the situation. His wife, in the face of more unsubstantiated claims from Linda Kitson that Arthur had secretly been in London, instructed Playfair to notify her eldest brother of the situation. As a result the £500 allowance was stopped.

Although Playfair issued a grudging apology when Arthur returned to England later in the year and (falsely) claimed that his wife's account of his secret visit to London was true, the allowance remained unpaid. This was the key factor in Linda Kitson's decision to sue Playfair for libel and slander. McLaren emphasises the point that while Playfair sought his defence in the concept of privileged communications, this was not related to his position as a doctor, but rather because the disclosure was made within the family. Thus medical confidentiality was not the issue at hand in the

¹⁴ For more on this element of state and notable trials see L Farmer, 'Notable Trials and the Criminal Law in Scotland and England, 1750-1950' in Ph Chassaigne and J-P Genet (eds.) *Droit et Societe en France et Grande Bretagne (12-20 siecles). Fonctions, Usages et Representations*, (Paris, 2003), 149-170.

¹⁵ A McLaren, 'Privileged Communications: Medical Confidentiality in Late Victorian Britain', *Medical History*, 37, (1993), 129-147.

trial, although Playfair's position as an eminent doctor, coupled with the fact that he had attended Linda Kitson in a medical capacity, led to comment being passed on the duty of the medical profession to notify cases of abortion. Despite being regarded as a high-profile case questioning the boundaries of medical confidentiality, largely because of comments made by the judge (Henry 'Hanging' Hawkins) during his summing-up, the medical aspect was incidental:

Hawkins himself refused to instruct the jury on whether or not a doctor who gratuitously revealed a patient's secret was making an illegitimate breach of confidence. So the general question was left unsettled, Hawkins leaving the issue of privileged communication as confused as ever.¹⁶

McLaren also demonstrates how, far from always being an impartial consideration of facts, the legal process was open to manipulation. Despite having the weight of medical opinion in support of his conclusion that Linda Kitson was suffering from a miscarriage or abortion stemming from an adulterous relationship, and her confession that she had lied about her husband being secretly in London, Playfair was found guilty of the charges and ordered to pay the considerable sum of £12,000 in damages. The reasons for this apparently illogical outcome can be found in the detail and context of the trial. McLaren points to the fact that a trial of this nature, involving the question of whether the royal accoucheur had exposed the adultery of his sister-in-law, raised public and press interest in the case.¹⁷ In turn, he emphasises the importance of appearance in influencing opinion, citing the manner in which Linda and Arthur Kitson succeeded in portraying themselves as innocent parties:

Linda Kitson was the picture of the affronted female; attractive but wracked by anxiety, dressed elegantly but demurely in black, a white rose at her throat. She wept; she swooned. The first day of her trial she almost fainted and was led by her husband into the open air. The judge asked her to sit while testifying. She spoke in a whisper; her water glass rattled against her teeth. When what the press described as the "ordeal" of her testifying was over, she ~~was~~ assisted from the box by her husband. He too made a good impression as

¹⁶ Ibid., 138.

¹⁷ Ibid., 140.

the poor relative fighting his wealthy and powerful family to protect the honour of his wife.¹⁸

Kitson's lawyer succeeded in promoting the idea that Linda Kitson was the innocent party who had suffered as a result of Playfair's actions as 'moral inquisitor'. While Victorian society had strong notions of morality, moral inquisitions were directed towards the lower classes of society. Kitson succeeded largely because she successfully portrayed herself as a wronged middle-class woman whose character had been unfairly brought into disrepute. In McLaren's words: 'Linda Kitson won much support by perfectly playing the role of the lady in distress'.¹⁹ The stress on the importance of class and gender is clear.

The question of medical confidentiality was raised during the questioning of the expert medical witnesses. As a crime, abortion was supposed to be notified, but when Hawkins asked Sir John Williams – a leading obstetrician giving evidence – whether he would report a woman who had attempted to procure abortion, his positive reply met with criticism.²⁰ Distinguishing between the letter and the spirit of the law

Hawkins went so far as to declare in open court that if a woman aborted to save her character, her reputation and her livelihood he doubted 'very, very, very much' the justification of a doctor running off to the police to say: 'I have been attending a poor, young woman who has been trying to procure abortion with the assistance of her sister. She is now pretty well, and is getting better, and in the course of a few days she will be out again, but I think I ought to put you on to the woman'.²¹

It was this statement, effectively unconnected with the facts of the case, which impacted on the debate over the boundaries of medical confidentiality heightening the confusion around the doctor's duty to notify cases of criminal abortion.

McLaren's work shows how issues such as gender, class and social context can influence the outcome of legal cases. Moreover *Kitson v Playfair* demonstrates how a judicial opinion on a matter not wholly relevant to the case – namely

¹⁸ Ibid., 135.

¹⁹ Ibid., 142.

²⁰ Ibid., 139.

²¹ Ibid., 145.

notification of abortion – could have significant repercussions. Many of these themes will be explored further in this thesis. While McLaren gives a fascinating account of an intriguing trial, by his own admission its impact for medical confidentiality was felt outside more than inside the courtroom. It contributed to the confusion surrounding the medical profession's duty to notify abortion and the high level of damages preyed on doctors' minds whenever disclosure of medical information left room for allegations of libel or slander. However, the case was not a legal precedent for confidentiality. A central objective in the current work is to apply the same style of historical analysis to the precedents that have had an impact on the legal definition of the boundaries of medical confidentiality. The case most frequently cited as determining the absence of medical privilege is the Duchess of Kingston's trial for bigamy in 1776. Called as a witness during the hearing in the House of Lords, Caesar Hawkins, Serjeant-Surgeon to the King, claimed that the required information was covered by medical privilege. The Lord Chief Justice, Lord Mansfield, ruled against the claim and his words have been cited as precedent on medical confidentiality ever since.²² Chapter 2 looks in detail at the historical context of the Duchess's trial with a view to gaining a greater understanding of the genesis of this long-standing and greatly influential precedent.

Hayek observes that the rule of law requires the enforcement of clearly stated and consistently applied rules which allow individuals to foresee with fair certainty how the authority will use its coercive powers in given circumstances.²³ An intention of the current work is to investigate the extent to which the law was clear and consistent in defining the boundaries of confidentiality with regard to the prominent issues of abortion and VD. Doctors had a statutory obligation to notify cases of criminal abortion, while VD treatment was bound by a well-publicised pledge of confidentiality from the Ministry of Health. Examination of these two issues will provide insight into the relationship between statute law, common law, governmental rules and professional ideals of conduct in determining the limits of medical confidentiality. Chapter 3 looks at the debate over abortion around the turn of the twentieth century and up until the First World War. The tension that resulted from differing interpretations of correct action with regard to abortion provides a necessary

²² Details of its citations are given in chapter 2 of the current work. For evidence of a late twentieth century citation of the case see J V McHale, *Medical Confidentiality and Legal Privilege* (London, 1993), 13.

²³ J Harris, *Legal Philosophies* (Edinburgh, 1997), 151.

backdrop to the intense debate over medical confidentiality in relation to VD in the early interwar years.

To a limited extent the historical examination of these debates was begun by Andrew Morrice. His MD thesis, examining the ethical issues addressed by the BMA in the first half of the twentieth century, led him to publish a paper on medical confidentiality covering the debate of the early interwar years.²⁴ As this was published during the preparation of this thesis, there has been some overlap with the present study. However, while Morrice provides an overview of part of the debate, his account is restricted in focus to the perspective of the BMA. It is a contention of this thesis that a subject, like medical confidentiality, involving a number of conflicting interest groups, benefits from multi-faceted analysis. The middle section of the thesis (chapters 4, 5 and 6) considers the dispute over medical confidentiality and VD from the perspectives of the three main protagonists: the Ministry of Health, the British Medical Association and the Lord Chancellor. For each group, examination will be made of the reasons for their involvement with the question, the individuals who played a significant role, and the justification for the positions they adopted. Such details will provide an insight into the practical process of debating the boundaries of medical confidentiality.

The final section (chapters 7 and 8) opens with an examination of the attempts (one in 1927 and the other in 1936) to promote a private member's bill endorsing medical privilege. Having discussed the difficulties inherent in changing the common law position on medical privilege in the middle section of the thesis, chapter 7 analyses the complexities of attempts to incorporate medical privilege into statute law. While the thesis takes a chronological approach in order to follow how issues developed over time, overlapped and intertwined, chapter 8 encapsulates a range of different issues from throughout the time period which demonstrate the breadth of areas where questions of the boundaries of medical confidentiality could be raised. The key themes and recurrent analogies of the study will be highlighted in the conclusion.

²⁴ A Morrice, 'Honour and Interests: Medical Ethics in Britain and the Work of the British Medical Association's Central Ethical Committee, 1902-1939' (MD thesis, University of London, 1999); A 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*, (London, 2002); see also A Morrice, 'Honour and Interests: Medical Ethics and the British Medical Association', in A H Maehle and J Geyer-Kordesch (eds) *Historical and Philosophical Perspectives on Biomedical Ethics* (Aldershot, 2002), 11-35.

As a crucible in which beliefs about medical confidentiality were severely tested, the interwar years of the twentieth century have the potential to provide useful historical insight on the development of the issue in Britain. However, to find the case frequently cited as the benchmark precedent in the debates of the 1920s, it is necessary to go back to the trial of a bigamous Duchess before her peers in the House of Lords in 1776. In terms of the law, it is here that the delineation of the boundaries of medical confidentiality begins.

Chapter 2 – The Duchess of Kingston’s Trial

‘A precedent embalms a principle’ stated Lord Stowell while Advocate-General, words echoed by Benjamin Disraeli in a speech in the House of Commons in 1848.¹ Medical ethics and the law share the same task of providing clear and fixed guidelines for practice, to be implemented within a context of, and to be reflective of the opinions and standards of, a perpetually changing society. For these reasons, there is a great emphasis placed upon the importance of legal precedent in the ongoing interpretation of the law. Single cases can have a lasting influence on individuals, professions and society as a whole, by means of clarifying penumbral issues within the legal framework and embalming the principle of the law for future practice. One such case was the trial of the Duchess of Kingston for the crime of bigamy in 1776.²

Many have been drawn to write accounts of the more scandalous aspects of the infamous Duchess’s life.³ This is unsurprising given the wealth of such material the Duchess provided. John Bernard Burke provides the following assessment of the Duchess in his mid-nineteenth century work, *Anecdotes of the Aristocracy*:

With talents of no mean order, with personal attractions that charmed every eye, and with accomplishments, captivating, even after the influence of beauty had ceased to exert itself, the celebrated lady, the heroine of the extraordinary episode in real life we are about to recount, lived a memorable example of the inefficacy of wealth or grandeur to secure happiness.⁴

Amongst the many memorable tales from the Duchess’s highly eventful life is her appearance at a Masquerade as the character of Iphigenia - her costume leaving her, in Burke’s words ‘almost in the unadorned simplicity of primitive nature’. There was also her brief career in politics, when, shortly after Bonnie Prince Charlie had captured Carlisle during the Jacobite uprising of 1745, and amidst a room full of

¹ J M and M J Cohen, *The Penguin Dictionary of Quotations*, (Harmondsworth, 1960), 307 & 140.

² Though she pleads in her married name of Elizabeth Pierrepont, for the sake of clarity she will throughout this paper be referred to as either ‘the Duchess’ or by her maiden name ‘Elizabeth Chudleigh’.—

³ B C Brown, *Elizabeth Chudleigh, Duchess of Kingston* (London, 1927); M Elwood, *The Bigamous Duchess. A romantic biography of Elizabeth Chudleigh, Duchess of Kingston* (New York, 1960); D. Leslie, *The incredible duchess: the life and times of Elizabeth Chudleigh*, (London, 1974), C Gervat, *Elizabeth. The Scandalous life of the Duchess of Kingston*, (London, 2003).

⁴ J Bernard Burke, *Anecdotes of the Aristocracy*, (London, 1849).

inebriated dinner guests at Leicester House, the Prince of Wales expressed his disapproval of the new government by dictating a letter giving instructions to appoint the young Elizabeth Chudleigh as Secretary for War. However, her many biographers have bypassed her significant, if unwitting, contribution to the definition of medical confidentiality. Even when the case is cited in writings on the history of medical ethics, it is done so *en passant*, with little discussion of the original details of the case.⁵ Yet, the story is no less scandalous than the other areas of Elizabeth Chudleigh's life. For the details of the trial reveal that the case which became the foundation of modern interpretations of medical confidentiality arose from little more than an attempt by a private surgeon, Caesar Hawkins, to secure his personal interests and status as a gentleman in eighteenth-century high society.

Elizabeth Chudleigh's indictment stated that she had married a second husband, Evelyn Pierrepont, Duke of Kingston, while her first husband, Augustus John Hervey, recently made Earl of Bristol, was still living. Standing accused of being twice married, she was rumoured to have been engaged originally to a third person, the Duke of Hamilton, a betrothal which never came to fruition as a result of the interference of her aunt, Mrs Hanmer. Obviously intent that her niece should discontinue the relationship with the Duke, she intercepted and destroyed the correspondence which he sent to Elizabeth Chudleigh whilst on his Grand Tour. Consequently Elizabeth believed he had lost interest in her and their engagement.⁶ It was under pressure from this same aunt that Elizabeth Chudleigh secretly married Hervey, by the light of a single candle, in a small church in Lainston in 1744. The reasons for such secrecy appear to have been that Hervey, as the younger son of a younger son, had no resources except his meagre pay from the Navy; while Elizabeth would lose her position as maid of honour to the Princess of Wales if she were known to be married.⁷ Following the ceremony, the couple spent the next three days together at Mrs Hanmer's house before Hervey returned to his ship and his wife, maintaining

⁵ A 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*, (London, 2002), 60-82, 64; A Morrice, ' "Honour and Interests" : Medical Ethics and the British Medical Association.' in A-H Maehle and J-Geyer-Kordesch (eds), *Historical and Philosophical Perspectives on Biomedical Ethics*, (Aldershot, 2002), 11-35, 26; A-H Maehle, 'Protecting Patient Privacy or Serving Public Interests? Challenges to Medical Confidentiality in Imperial Germany', *Social History of Medicine*, 16 (2003), 383-401, 400.

⁶ J Lee Osborn, *Lainston and Elizabeth Chudleigh*, (Winchester, 1915), 6.

⁷ Brown, *Elizabeth Chudleigh*, 18 ; Lee Osborn, *Lainston*, 6-7.

her name as Elizabeth Chudleigh and her status of maid, returned to her service in Leicester House.

Hervey was abroad for approximately two years. In that period there was little, if any, correspondence between the newly weds. On his return to London, Hervey had to threaten to publish the fact of their marriage in order to gain an audience with his wife. Nonetheless, in the following November Elizabeth Chudleigh was delivered of their only child, a boy who died when only a few months old. Over the next twenty years, with a series of deaths making it increasingly likely that Hervey would become the next Earl of Bristol, Elizabeth Chudleigh seemed to be torn between trying firmly to establish their marriage, potentially making her the Countess of Bristol, and denying that the wedding had ever taken place, leaving her free to seek marriage and title elsewhere. In 1769, using the couple's mutual friend and surgeon, Caesar Hawkins, as a messenger Hervey indicated to his wife that he wanted a divorce. In response, Elizabeth Chudleigh instigated a suit, heard in an ecclesiastical court, against Hervey for "jactitation" of marriage - an injunction against Hervey making, what she argued were, false claims about them being married.⁸ Although the case was decided in her favour, Hervey's weak defence led many to suspect that the whole suit was a collusive venture by the couple, both of whom wanted to remarry. Only Elizabeth Chudleigh did so, becoming the Duchess of Kingston shortly after the suit ended. After five years of marriage, the Duke of Kingston died, leaving her the bulk of his property and wealth in his will. This was not well received by the Duke's nephews, Evelyn and Charles Meadows. The former was entirely passed over in the will, and the latter was the next heir to the estate. Potentially, both had much to gain if they could establish the prior marriage between the Duchess, by now living in Rome, and the new Earl of Bristol. It was as a result of their efforts that on Monday 15 April 1776, Elizabeth Chudleigh, Duchess Dowager of Kingston stood trial in Westminster Hall for the crime of bigamy.

The trial of a duchess in front of the House of Peers naturally received much publicity at the time. *The Gentleman's Magazine* of that year showed a continued interest in all things connected with the trial. In its January edition it reported that the date of the trial had been fixed for 15 April. The following month it noted the appointment of the Lord High Steward on the trial by the King. In March, it reported a

⁸ "Jactitation of marriage": A false assertion that one is married to someone to whom one is not in fact married. E A Martin (ed) *A Dictionary of Law*, (Oxford, 2002).

motion considered by the House of Peers on whether they could legally proceed with the trial, the decision being made in the affirmative.⁹ The resultant crescendo of publicity meant that by the time the full account of the trial was printed in the magazine, it came with a postscript stating: 'The importance of the above trial, and our desire to gratify our readers with the substance of it at once, has obliged us to postpone the Account of American Affairs'. Its priority over American affairs at the time of the War of Independence highlights the impact of the Duchess's trial. Similarly, *The Annual Register* for 1776 devoted six pages to a detailed account of the trial.¹⁰ Samuel Foote's play: *A trip to Calais*, published in 1778, prolonged the public interest in the Duchess with an overt character-assassination of her through the fictional Lady Kitty Crocodile.¹¹ The Duchess attempted to suppress the publication of the play by offering Foote financial incentives, though when these were rejected, her friend Lord Mountstuart approached the lord chamberlain in an unsuccessful attempt to forbid its production¹².

The unique circumstances surrounding the case have resulted in citations of the Duchess's trial being found in cases ranging from those focused on confidentiality in the practice of both law and medicine, to those which raise the question of the re-litigation of issues. This last point was discussed at length in the Duchess's case, because of the prior ecclesiastical hearing, and it is noteworthy that the decisions reached thereby were cited in the first appeal trial of the Birmingham six in 1980.¹³

The trial itself was resplendent in ceremony, replete with all the etiquette and display of courtesy which the trial of a duchess by her peers in full parliament demanded. Hannah More, the eighteenth-century writer, provided the following description:

Garrick would have me take his ticket to go to the trial of the Duchess of Kingston; a sight which, for beauty and magnificence, exceeded any thing which those who were never present at a coronation or a trial by peers can

⁹ *The Gentleman's Magazine and Historical Chronicle*, 46 (1776).

¹⁰ *The Annual Register, or a view of the history, politics, and literature for the year 1776*, (London, 1788).

¹¹ S Foote, *A trip to Calais; a comedy in three acts*, (London, 1778).

¹² <http://www.southfrm.demon.co.uk/Bigamy/Chudleigh.html>

¹³ *Hunter v Chief Constable of the West Midlands* [1980] Q.B. 283.

have the least notion of. Mrs Garrick and I were in full dress by seven... You will imagine the bustle of five thousand people getting into one hall!¹⁴

After a description of the grand entrance of the Peers into the court at Westminster, Bathurst's account of the trial relates how the Duchess was called and brought, making three reverences on her approach before falling to her knees at the Bar. On being permitted to rise by the Lord High Steward, the Duchess curtsied to the Lord High Steward and to the House of Peers, the compliment being returned her by his Grace, and the Lords.¹⁵

Granted permission to address the court, the Duchess recounted her voluntary return from Rome, at serious risk to her life, in order to submit to the law. She requested that the court would understand that her poor health and oppressed spirits affected her ability to recollect certain facts, but 'it can only be with the loss of life, that I can be deprived of the knowledge of the respect that is due to this high and awful tribunal.'¹⁶ Such dramatic and overstated deference make it simple to see where Foote found inspiration. The Duchess attempted to win the support of those who stood in judgement of her by portraying herself not only as courteous and co-operative, but as an ill and oppressed lady. These traits are reflected in the manipulation and self-interest, concealed behind a façade of grief for her dead husband, in Foote's characterization of the Duchess as Kitty Crocodile.

Theatrics aside, there could be no doubt of the seriousness of the charge. In court it was stated that bigamy was

A crime so destructive of the peace and happiness of private families, and so injurious in its consequences to the welfare and good order of society, that by statute law of this Kingdom it was for many years (in your sex) punishable with death; the lenity, however, of later times has substituted a milder punishment in its stead.¹⁷

It is worth noting not only the severity of the charge, but also the description of the ill effects of the crime. It was destructive to private families and it had injurious

¹⁴ R Hole (ed.), *Selected Writings of Hannah More* (London, 1996), 12.

¹⁵ *The trial of Elizabeth Duchess Dowager of Kingston for bigamy* (London, 1776), 7.

¹⁶ *Ibid.*, 8.

¹⁷ *Ibid.*, 7

consequences for society. These two factors emphasize the intrusion into family life which the law saw as necessary to protect the welfare of society. In legal proceedings of this nature, such intrusion was inevitable, but it became increasingly evident as witnesses were called to testify, that there was doubt over its nature and extent. This is a clear example of the fundamental point that medical confidentiality is not in itself morally valuable, but rather derives its moral worth from the balance it maintains between the interests of the individual and society.¹⁸ That the social welfare could be adversely affected by an individual's behaviour emphasized the apparent potential for conflict between a patient's interests in maintaining secrecy, a doctor's interests in maintaining honour and the wider interests of society.

The first witness to be called was Ann Craddock, servant to Elizabeth Chudleigh's aunt, the interfering Mrs Hanmer, and wife of Hervey's servant¹⁹. She was very forthcoming with her evidence, testifying that she witnessed the marriage between the accused and Hervey and saw the parties in bed together afterwards. Craddock stated that while she never actually saw a child from the marriage, she did observe that Elizabeth Chudleigh appeared to be with child. Subsequently, the accused told her that a boy had been born in Chelsea but before she was taken to see him, Elizabeth Chudleigh informed her that the boy had died. Anne Craddock's evidence was straightforward – she made no protest when asked to give evidence and was perfectly willing to divulge information received in conversation with the accused. This was not a pattern repeated with subsequent witnesses.

Next called to give evidence, and central to the present interest in this case, was the surgeon, Caesar Hawkins. Hawkins had served as Serjeant-Surgeon to King George II, and, at the time of the trial, held the same post to George III.²⁰ He had known Elizabeth Chudleigh and Hervey for around thirty years, initially attending them in a professional capacity, an acquaintance which had developed into friendship. Counsel, on asking if Hawkins knew from the parties of any marriage between them, received the reply: 'I do not know how far any thing, that has come before me in a confidential trust in my profession, should be disclosed, consistent with my professional honour.'²¹ The question and answer were repeated. With Hawkins's

¹⁸ R Gillon, *Philosophical Medical Ethics* (Chippenham, 1985), 107-8.

¹⁹ This marriage took place in 1752, after the marriage of Chudleigh and Hervey, and is noted here as it shows Craddock had links with both families.

²⁰ C Hibbert, *George III. A Personal History*, (London, 1998), 67-8.

²¹ *The Trial of Elizabeth* (London, 1776), 119.

reluctance to answer, the question was referred to the Peers to decide, and there followed a lengthy statement on the matter by Lord Mansfield.

Mansfield (William Murray) was a highly influential Lord Chief Justice, renowned for his emphasis on making prompt decisions. Noting the pronounced laxity in the practices for the reporting of precedent in the eighteenth century, James Oldham indicates that this goes some way to explaining the 'rarity of cases in which Mansfield was prevented by prior authority from reaching a desired result.'²² However, Mansfield's authoritative approach did not meet with universal approval. Oldham notes that critics saw his 'chancellorlike' behaviour as inappropriate for a common law judge.²³ Nonetheless, Mansfield carried a great deal of influence in the shaping of the law in the second half of the eighteenth century.²⁴ In what seems to have been a typically quick and definitive response, he stated:

I suppose Mr. Hawkins means to demur to the question upon the ground, that it came to his knowledge some way, from his being employed as a surgeon for one or both of the parties; and I take it for granted, if Mr. Hawkins, understands that it is your Lordships opinion, that he has no privilege on that account to excuse himself from giving the answer, that then, under the authority of your Lordships judgement, he will submit to answer it : Therefore, to save your Lordships the trouble of an adjournement, if no Lord differs in opinion, but thinks that a surgeon has no privilege to avoid giving evidence in a court of justice, but is bound by the law of the land to do it; [if any of your Lordships think he has such a privilege, it will be a matter to be debated elsewhere, but] if all your Lordships acquiesce, Mr. Hawkins will understand, that it is your judgement and opinion, that a surgeon has no privilege, where it is a material question, in a civil or criminal cause, to know whether parties were married, or whether a child was born, to say, that his introduction to the parties was in the course of his profession, and that in that way he came to knowledge of it. I take it for granted, that if Mr. Hawkins understands that, it is a satisfaction to him, and a clear justification to all the world. If a surgeon

²² J Oldham, *The Mansfield Manuscripts and the Growth of English Law in the Eighteenth Century*, vol.1, (London, 1992), 105.

²³ Ibid., 107.

²⁴ An account of his life can be found both in the *Dictionary of National Biography* and in *The International Magazine of Literature, Art and Science*, vol.1, 3 (1850).

was voluntarily to reveal these secrets, to be sure he would be guilty of a breach of honour, and of great indiscretion; but, to give that information in a court of justice, which by the law of the land he is bound to do, will never be imputed to him as any indiscretion whatever.²⁵

The rest of the House, without discussion, agreed. Seemingly placated by this response, Hawkins answered the question by stating he had understood, from the conversation between the two parties, that there was a marriage but that he had nothing of proof ‘I mean nothing as legal proof, but *conversation*.’²⁶ The importance of the stress on the word ‘conversation’, as it appears in the original text, must not be overlooked. At this stage of his evidence, Hawkins was not revealing information he had gained by virtue of his status as a medical man. Rather, the question of divulging information was more fundamentally grounded in honour. His introduction to the two parties involved in the case had been on a professional level, when he was called to be present at the birth of their child. Though present, Hawkins did not deliver the child himself and at the trial he stated he could not remember who had delivered it. However, professional attendance aside, his knowledge of any marriage between them was gained through conversation. Much of the medical world of the eighteenth century equated ethical practice with courtesy, manners and etiquette – a hierarchical world in which successful practitioners strove for the status of gentlemen.²⁷ Hawkins’s request not to break the confidences of the two parties was based on the ethic of a gentleman’s honour. As noted earlier, Hervey and Elizabeth Chudleigh had used Hawkins as their mutual envoy in the correspondence preceding the ecclesiastical trial. During his evidence in the criminal trial, Hawkins recounted how Hervey had wished to convey to his wife the regard and respect which he had for her and to assure her that he would

appear and act on the line of a man of honour and of a gentleman; that he wished (he said) she would understand that his soliciting me to carry the message should be received by her as a mark of that disposition.²⁸

²⁵ *The Trial of Elizabeth* (London, 1776), 120.

²⁶ *Ibid.*, 120

²⁷ M E Fissel, ‘Innocent and Honourable Bribes: Medical Manners in Eighteenth Century Britain’, in R Baker et al. (eds.), *The codification of medical morality*, (Dordrecht, 1993), 19-45, 25.

²⁸ *The Trial of Elizabeth* (London, 1776), 122.

Hawkins was thus being entrusted not only with the delivering of the pertinent information from one party to the next, but with being a symbol of gentlemanly honour. Put in this context, it is clear that during the trial he was keen not to betray the trust which had been put in him, and, what is more, he was trying to accentuate the status of honourable and trustworthy gentleman bestowed upon him by Hervey. While Hawkins may have been drawing on a perceived long-standing duty of medical practitioners to maintain patient confidences, his actions, when seen within the specific context of this trial, show Hawkins to be making his request in a manner that would appeal to the code of honour of the upper echelons of society represented in the courtroom.

It is of little surprise that a trial of this nature, at this time, became centrally focused on the issue of honour. The honour of the peerage was itself being brought into question with such a scandalous trial for a crime involving three of its members. Similarly, it should come as no surprise that a medical man was so prominent in the proceedings. By virtue of their profession, medical men were party to private and sensitive information about patients and their families. Recognizing this, the contemporary medical ethicist John Gregory wrote: 'Hence appears how much the characters of individuals, and the credit of families may sometimes depend on the discretion, secrecy, and honour of a physician.'²⁹ In light of these words, it is worthy of particular note that it was a surgeon, not the socially superior physician, who was embroiled in the wrangle for recognition within the role of honourable gentleman, on the high-profile stage of this prominent trial in such a powerful court.

Hawkins was the first of the witnesses to question the extent to which information should be divulged in keeping with honour, but he was not the last. The Honourable Sophia Charlotte Fettiplace requested to be excused from giving evidence on the grounds that she had no knowledge of the issue other than what arose from her former connection as friend and confidante of the Duchess. The Lord High Steward responded with a categorical statement that she must disclose what she knew for the purposes of justice.³⁰ Still the issue was not resolved.

²⁹ As quoted in L B McCullough, *John Gregory and the Invention of Professional Medical Ethics and the Profession of Medicine*, (Dordrecht, 1998), 223.

³⁰ *The Trial of Elizabeth* (London, 1776), 126.

The next witness was Viscount Barrington. While each of the reports of the trial lists Barrington simply as a friend of the Duchess, William Wildman Barrington served as Member of Parliament for Berwick-upon-Tweed and later Plymouth. He held a number of official posts throughout his career, including Chancellor of the Exchequer, and at the time of the trial he was in his second term as Secretary for War. His opening remarks made clear his reluctance to follow the court's line of thought and divulge all information

if any thing has been confided to my Honour, or confidentially told me, I do hold, with humble submission to your Lordships, that as a man of honour, as a man regardful of the laws of society, I cannot reveal it.³¹

When reminded of the court's reaction to Hawkins's request for privilege, Barrington acknowledged the court's response but stated: 'I think every man must act from his own feelings, and I feel, that any Private Conversation intrusted to me, is not to be reported again.'³² This is a very important statement. Barrington asserted that it would contravene his honour to reveal what he had learned in conversation with the Duchess, yet that is precisely the method by which Hawkins had apprehended that there was a marriage - information he had been forced to divulge.

While Hawkins received a unanimous rebuff to his request to maintain confidences, Barrington's petition, at least initially, fell on more sympathetic ears. In the discussion in open court, Lord Camden stated: 'As to casuistical points, how far he should conceal or suppress that, which the justice of his country calls upon him to reveal, that I must leave to the witness's own conscience.'³³ Camden may have imposed the weight of the situation on Barrington's conscience, but this was clearly more lenient in contrast to the Lord High Steward's categorical response to Sophia Charlotte Fettiplace. The Duke of Richmond went further: 'For one I think it would be improper in the noble Lord to betray any private conversations. I submit to your Lordships, that every matter of fact, not of conversation, which can be requested, the noble Lord is bound to disclose.'³⁴

³¹ Ibid., 127.

³² Ibid., 127.

³³ Ibid., 128.

³⁴ Ibid., 127.

After an adjournment of some time to discuss the matter, the Peers returned and the Lord High Steward informed Barrington that they had judged that he was bound by law to answer all questions put to him. The matter being seemingly decided, both counsel for the prosecution and defence stated that they had no questions for Barrington. Thus, even when the court had taken the opportunity to adjourn and consider the matter – more than was deemed necessary when Hawkins made his request – the two opposing counsels were reluctant to compromise Barrington's honour. Lord Radnor, however, did take the opportunity to ask Barrington direct questions relating to his conversations with the Duchess which made mention of her marriage to Hervey. Having taken further advice from counsel, Barrington gave a tentative but positive response, making the evasive qualification that he was not lawyer or civilian enough to judge whether it was a legal marriage.³⁵

The first witness for the defence was Berkley, attorney to Hervey. He immediately declared his interest in the cause, stating that his knowledge of the business arose from his professional position in relation to Hervey. Consequently, he posed a similar question as Hawkins and Barrington had done before him: Did his professional position as attorney to one of the parties in the cause exempt him from answering questions from counsel? In his own words, would the disclosing of information gained in the lawyer-client relationship be 'consistent with honour to myself and the duty I owe to him.'³⁶ As with Hawkins, it was Mansfield who attempted to clarify the legal position by stating that the privilege of attorneys extended only to information received from clients in order to gain legal advice relevant to their defence. The questions being put to Berkley did not request the divulging of secrets of the client, but rather sought collateral facts and 'it has often been determined, that as to fact an attorney or counsel has no privilege to withhold his evidence.'³⁷ It is noteworthy that Mansfield treated this as a firmly established point of law, and he concluded his remarks by stating his supposition that Berkley only raised the question in order to justify his action in giving evidence. Questions proceeded and Berkley co-operated in answering them.

Professional and personal honour were prominent themes throughout the trial, and it is worth pausing to consider the court's reaction to the various petitions for

³⁵ Ibid., 130.

³⁶ Ibid., 146.

³⁷ Ibid., 146.

exemption from testifying. In Hawkins's case, his request was unanimously thrown out with no discussion beyond the statement by Mansfield. When Berkley was called, he sought clarification on his position relative to the established privilege granted to members of the legal profession. The reply of Mansfield recognized the existence of a qualified legal privilege and his assertion that Berkley was only looking for justification of his giving evidence, is a clear demonstration of Berkley's desire to maintain honour and reputation while satisfying the court's requirements. This point also holds true for Hawkins. A medical man in the eighteenth century relied on reputation, perceived status and etiquette in order to gain wealthy patients and the accompanying fees. By appealing for privilege on the basis of his professional status, Hawkins was attempting to safeguard his reputation as an honourable and trustworthy gentleman. Such overt moral characteristics were central to the success of his practice and, consequently, his livelihood.

Kiernan, in his examination of the code of honour amongst the upper classes, provides two alternative sources for a sense of honour: innate virtue or conformity to stereotyped rules of conduct. In practice, he states: 'an individual's honour...had little to do with any ethical convictions; its meaning was much closer to 'prestige'...[used] to impress his underlings as well as his peers.'³⁸ There is little doubt that a large element of the motive of each of the witnesses who challenged the court on the question of honour, can be attributed to the individual's desire for personal prestige and recognition by such a distinguished court. Yet perhaps a slightly different light should be cast over Hawkins's motivations.

Roy Porter's analysis of the career of the famous eighteenth-century surgeon William Hunter shows how mainstream histories of medicine which compartmentalized physicians, surgeons and apothecaries into a three-tiered hierarchy in which only the physician could achieve the status of gentleman, were overly rigid.³⁹ Rather, while hierarchy did exist, the power which the patient had to choose from the wide variety of formal and informal healers available left opportunity enough for enterprising individuals to gain social advancement and wealthy clients,

³⁸ V G Kiernan, *The Duel in European History. Honour and the Reign of the Aristocracy*, (Oxford, 1988), 155.

³⁹ R Porter, 'William Hunter: a Surgeon and a Gentleman', in W F Bynum and R Porter (eds.), *William Hunter and the Eighteenth Century Medical World*, (Cambridge, 1985), 7.

without practising physic.⁴⁰ Porter draws on Jewson's classic paper on eighteenth-century medical life in which he states that the ethical propriety of medical men was a central criterion for their selection. While the ambitious physician was required to establish his credentials as a gentleman, he further had to distinguish himself from the rest of the marketplace crowd. So, as Jewson states: 'Physicians were encouraged therefore to bring themselves before the public eye by every devious method of self advertisement their prolific ingenuity could devise.'⁴¹

In light of Porter and Jewson, it is possible to view Hawkins's performance in court, not so much as a demonstration of status to equals and underlings, but rather as a defence of his elite position within the profession, with all its financial trappings, by using his enforced appearance in court as a means to advertise his ethical propriety to a courtroom attended by Royalty, filled with Peers, and on, through conversation and publication, to the wider public.⁴² As noted earlier, the continued coverage of the trial in *The Gentleman's Magazine* gives an indication of the interest shown in the Duchess's trial. This would have brought Hawkins's connection with, and performance in, the witness-box to the attention of many clients, actual and potential, amongst the upper class. At its peak this publication had an estimated circulation of over 10,000 copies and far more readers. In Porter's words, it can 'thus safely be assumed to mirror the sober opinions of the enlightened reading elite, the catholic taste of anyone with the rank, education, or presumption to consider himself genteel.'⁴³ Certainly, the proceedings did Hawkins's career no harm: he became a Baronet in 1778.

While all witnesses were eventually compelled to answer all questions put to them, there were vast differences in the method and manner of treatment they received from the court. While Hawkins's request was rapidly rejected, Barrington's was given far more consideration, indeed the court was adjourned while the matter was debated, and there was certainly some evidence of agreement with his position. The conversation between a viscount and a duchess would seem to have been more worthy of consideration for a privilege of confidentiality than that between a medical

⁴⁰ An interesting account of the eighteenth century patient's viewpoint is given in R Porter, 'Lay Medical Knowledge in the Eighteenth Century: the Evidence of the Gentleman's Magazine', *Medical History*, 29 (1985), 138-168.

⁴¹ N D Jewson, 'Medical Knowledge and the Patronage System in 18th Century England', *Sociology*, 13 (1974), 379.

⁴² C Pelham *The Chronicles of Crime; or, the Newgate Calendar* vol.1 (London, 1845), 261.

⁴³ R Porter, 'Lay Medical Knowledge', 141.

man and his clients. Or perhaps the court was more willing to accommodate the principle of private duty as asserted by a viscount in his platonic dealings with a duchess, when compared with a similar plea from a medical man whose desire for honour was entangled with his commercial interests, thereby compromising the purity of his appeal to moral principles.

The Duchess was unanimously found guilty of the crime of bigamy. The decision itself must have proved quite a spectacle as each of 119 members of the House of Peers, starting with the youngest, the Duke of Argyll, stood in turn, placed their right hand on their chest and declared 'Guilty, upon my honour.'⁴⁴ It is no small irony that the only claim for privilege which was successful in its petition to the court, was the guilty Duchess's request for the privilege of the peerage, exempting her from corporal punishment.⁴⁵ After her trial the Duchess, hearing that the Duke's nephews were about to proceed against her, left England, being conveyed across the Channel to Calais in an open boat by the captain of her yacht on the very day that a *ne exeat regno* was issued against her. She was, however, left in possession of her fortune.

The English legal system has a firm historical foundation in common law and judicial precedent. Even with the vast increase in statute law in the nineteenth-century, much of which confirmed prior practice, judicial precedent was still highly influential via its interpretation of penumbral issues. As Chief Justice Lord Kenyon put it in 1792, the discretion of the court 'will be best exercised by not deviating from the rules laid down by our predecessors; for the practice of the Court forms the law of the Court.'⁴⁶ A.H. Manchester points out that one of the crucial elements in a judge's awareness and knowledge of the common law was gained through accurate published reporting of cases.⁴⁷ While this was not a widespread practice in the eighteenth-century, the perceived importance of the Duchess's case led the House of Peers to order an official report to be made. In fact, in addition to Bathurst's account of the trial published in 1776, the case was fully reported by both Hargrave in his collection of State trials in

⁴⁴ T B Howell, *A complete collection of State Trials and proceedings for high treason and other crimes and misdemeanours from the earliest period to 1783*, (London, 1816), 623-5.

⁴⁵ *The Annual Register* 1776, 236.

⁴⁶ *Wilson v Rastall*, *The English Reports*, vol.99, King's Bench Division, Term Reports (Edinburgh, 1909), 1286.

⁴⁷ A H Manchester, *A Modern Legal History of England and Wales 1750-1950*, (London, 1980), 23

1781 and by Howell in a similar work published in 1816.⁴⁸ Clearly then, in addition to the populist reporting of the case, the legal mind was given ample opportunity to read any one of at least three verbatim accounts of the trial.⁴⁹ Evidence that these reports were read and impacted upon practice can be found in several later cases in which questions of confidentiality and privilege were raised. The ruling against Caesar Hawkins was cited by Justice Buller in *Wilson v Rastall*, 1792. The case related to the bribing of voters in an election in which it was clearly stated that privilege extended only to members of the legal profession when they were acting in that specific capacity in preparation for legal proceedings.⁵⁰ *Wilson v Rastall* was, in turn, further cited in *Rex v Gibbons*, 1823. In this latter case, a surgeon, called to give evidence as to a confession made to him by a woman accused of murdering her bastard child, objected on grounds of professional privilege. The judge dismissed this appeal to privilege, drawing attention to the fact that the Duchess's case had made clear the duty to disclose which the law imposed upon a medical man in court. *Rex v Gibbons*, was later cited by Lord Chief Justice Best in the case of *Broad v Pitt*, 1828. During this case a witness was called who had been attorney for the defendant. He was asked about a conversation which he had had with the defendant, when the defendant had executed a deed which the witness had prepared for him as his professional adviser. The witness contended that the conversation was confidential, but was ruled against on grounds that the communication was not made for the purposes of bringing or defending a legal action. Amidst what became a famous statement on the secrecy attached to confessions to a clergyman, Best clearly indicated that there was no privilege for a medical man and cited the Duchess's case as evidence.

The House of Lords was the highest court of appeal in Britain, except with regard to criminal cases in Scotland. As the Duchess was tried for the crime of bigamy, the decisions established by the Lords were not binding on the Scottish criminal courts.⁵¹ It is therefore important to examine the impact of the Duchess's trial in Scotland. In addition to the published reports, written treatises were a further

⁴⁸ F Hargrave, *A Complete Collection of State Trials*, vol. 11, (London, 1781); T B Howell, *A Complete Collection of State Trials*, (London, 1816).

⁴⁹ This is not an exhaustive list. For example Lewis Melville included the Duchess's trial in his *Notable British Trial-Series* (Edinburgh and London, 1927 & 1996 reprint).

⁵⁰ *The English Reports*, vol. 99, 1286.

⁵¹ While the present focus is on the Duchess's impact in Britain, the trial's circumstances had ramifications which were felt much further afield. See for instance *Rossiter v Thornton*, 1834. This was heard in The Supreme Court of New South Wales and is reported in the *Sydney Herald* 10 March 1834.

source of the principles of law as established in particular decisions. Interestingly, a number of the key nineteenth-century Scottish commentators categorically stated that surgeons and physicians had no privilege in a court of law, but cited no cases in relation to this point.⁵² One exception was William Gillespie Dickson, whose treatise cited the Duchess of Kingston as its earliest precedent.⁵³

Another case to which Dickson pays particular attention is that of *AB v CD*, 1851.⁵⁴ Heard in the Scottish Court of Session, the case established in Scottish Law that secrecy was an essential element of the contract between a medical man and his employers. The case involved an elder of the Kirk Session in an undisclosed parish in Scotland, whose wife gave birth to a child only six months after their marriage. In a misunderstanding of his position, the medical man called in to give his opinion on the age of the child, indicated to the Minister of the parish that the child was not premature. The elder was dismissed from the Kirk Session and brought an action against the doctor for breach of confidentiality. The doctor's lawyers attempted to counter this on the grounds that secrecy could not be taken to be an essential element of the contract between a medical man and his clients as there were instances in which the medical man could be forced to divulge patient information. Their justification for this position was the fact that a medical man could not claim privilege in court and their precedent was the Duchess of Kingston. Although the court did not accept the defence's argument with regard to there being *no* secrecy involved in the doctor-client relationship, Lord Fullerton did make clear that the medical profession did not have any form of privilege to decline giving evidence in a court of law.

While *AB v CD*, 1851 is the earliest case cited in many works relating to medical confidentiality in Scotland, the issue of medical *privilege* was not raised for discussion, but rather received passing comment by one of the Judges in the case. In fact, while the Duchess's trial was cited in further Scottish cases, it appears that the specific question of medical privilege was never the issue of immediate focus.⁵⁵ Thus,

⁵² See for instance: D Hume, *Commentaries on the Law of Scotland, Respecting Crimes*, 2nd ed. Vol.2 (Edinburgh, 1819), 338; J Burnett, *A Treatise on Various Branches of the Criminal Law of Scotland*, (Edinburgh, 1811), 437; G Tait, *A Treatise on the Law of Evidence in Scotland*, 3rd ed. (Edinburgh, 1834), 387.

⁵³ W G Dickson, *A Treatise on the Law of Evidence in Scotland* vol. 2, (Edinburgh, 1855), 1095. Repeated verbatim in the 1864 edition.

⁵⁴ *AB v CD* 14 D 177.

⁵⁵ See for example: *AB v CD* 7 Fraser (Court of Session) 72; *Watson v McKeown*, 12 SLT 248 & 599 & 13 SLT 340 & 7 Fraser (Court of Session) 109. The point also holds true for English cases, see: *Wilson v Rastall The English Reports*, vol. 99, 1286.

even Wilkinson, writing in 1986, was forced to state that while there is no reported Scottish decision on the point, 'it is settled practice that he (a medical practitioner) may also be compelled to speak to communications passing between him and his patient.'⁵⁶ The case cited with this is once again *AB v CD* from 1851. With Wilkinson's work being cited, in connection with the absence of medical privilege in the witness box, by the online edition of the *Stair Memorial Encyclopedia*, it is quite clear that the Duchess's impact in Scotland was not inconsiderable.⁵⁷

The discipline of medical jurisprudence, encompassing both forensic medicine and medical police, was gaining impetus as a necessary element of taught medical education throughout the eighteenth-century.⁵⁸ The very public appearance of medical men in the witness box was a severe testing ground not just for the individuals involved but also for the reputation of the professions they represented. One contemporary commentator went as far as to question: 'Is there any object of dread, paramount in the eye of the medical practitioner, to the *witness-box*?'⁵⁹ In response to this situation, courses of medical jurisprudence began to be incorporated into medical teaching. In conjunction with the rise in taught courses, there was also a burst of literature on the subject in the early nineteenth-century. In their 1823 textbook of medical jurisprudence, one of the earliest in Britain, Paris and Fonblanque cite the trial of the Duchess in a section dealing with confidentiality. The advice given follows the line of thought taken by Mansfield during the trial, and they quote in full his statement on the matter.⁶⁰ This work was further cited by many other writers and commentators in the field, thereby bringing the attention of students and practitioners of law and medicine to the Duchess's case, ensuring its continued influence in the growing field of medical jurisprudence.⁶¹

However, not all commentators shared the same view. John Gordon Smith, while recognizing the power which legal precedent contained on the issue of medical

⁵⁶ A B Wilkinson, *The Scottish Law of Evidence* (London & Edinburgh, 1986), 105.

⁵⁷ Stair Memorial Encyclopedia available online at:

http://wilson.butterworths.co.uk/stair/scotslawonline/index_los.htm

⁵⁸ A Todd Thomson, *Lecture, Introductory to the Course of Medical Jurisprudence, Delivered in the University of London, on Friday January 7th 1831*, (London, 1831), 9.

⁵⁹ J G Smith, *An Analysis of Medical Evidence : Comprising Directions for Practitioners, in View of Becoming Witnesses in Courts of Justice and an Appendix of Professional Testimony*, (London, 1825), 5.

⁶⁰ J A Paris and J S M Fonblanque, *Medical Jurisprudence*, (London, 1823), 160.

⁶¹ See for example: Todd Thomson, *Lecture*, (London, 1831), 9-10; T S Traill, *Outlines of a Course of Lectures on Medical Jurisprudence* (Edinburgh, 1840); R Lyall, *The Medical Evidence Relative to the Duration of Human Pregnancy as Given in the Gardner Peerage Case*, (London, 1826)

confidentiality, presented an alternative viewpoint, based not on the previous practice of the courts or national law, but rather on theories of general right.⁶² Moreover, dissent was not only to be found in textbooks, but also in the judgements of some courts. In the Scottish case of *McDonald v McDonalds* 1881, in which an insurance company tried to claim privilege with regard to a medical report they were asked to produce in evidence, it was stated that

although it has been decided by the English Courts that a medical man who acquires information from his patient....cannot refuse in a Court of Justice to disclose the information they possess, yet these decisions have been regretted by later English Judges, and none have been pronounced hitherto by the Scottish Courts.⁶³

Possibly reference was being made to the comments of Buller in the case of *Wilson v Rastall* in 1792 in which, citing the example of Caesar Hawkins in the Duchess's case, he lamented that the law of privilege was not extended to information gained by medical practitioners in the practice of their profession.⁶⁴ Even such a high legal authority as Lord Chancellor Brougham in his decision in *Greenough v Gaskell*, 1833 raised questions over the wisdom of the current state of the law. In his discussion of the legal privilege enjoyed by lawyers, he observed: 'it may not be very easy to discover why a like privilege has been refused to others, and especially to medical advisers.'⁶⁵ While not all commentators or judges agreed with the decision in the Duchess's case, the law remained unchanged. When, at the outset of the twentieth-century, John Glaister, professor of medical jurisprudence and toxicology at the University of Glasgow, came to write his influential textbook of *Medical Jurisprudence and Toxicology*, he indicated that the absence of any privilege for medical witnesses was the established law of the land. This, he stated, had been first

⁶² Smith treats breach of confidentiality when absolutely required in court as firmly established by legal precedent. In a footnote relating to the courts at Westminster he states: 'Perhaps it may not be impertinent to call the particular attention of the reader to the nature of the courts that sit there. In the Appendix, will be found illustrations as to what has been ruled on this point: in one instance in the *House of Peers*, which on the occasion in question, sat in Westminster Hall.' This seems to be a reference to the Duchess of Kingston Trial. Smith, *Analysis of Medical Evidence*, 92.

⁶³ *McDonald v McDonalds* 8 R 357

⁶⁴ *Wilson v Rastall*, *The English Reports*, vol.99, 1286.

⁶⁵ 1 MY & K 98.

laid down by Lord Mansfield in the Duchess of Kingston's trial from which he quoted at some length.⁶⁶

A further indication of the fundamental importance of the Duchess's case is the fact that it resurfaced in various guises whenever the question of medical confidentiality was brought to widespread attention. In 1896, at the time of the infamous *Kitson v Playfair* case, when, as noted in the last chapter, the Royal accoucheur was found guilty of slander and fined £12,000, the *British Medical Journal* for that year contained two articles which cited the Duchess of Kingston Trial as the benchmark precedent.⁶⁷ When, in 1899, the Russian ambassador sought advice on Britain's policy on medical confidentiality, the Home Office referred the request to the General Medical Council.⁶⁸ The resultant memo, indicating that the absence of any privilege of confidentiality had been established at the Duchess's trial, was published in the *BMJ*.⁶⁹ Similarly, in the early 1920s when there were a number of high profile legal cases in which medical privilege was claimed, the Duchess's case was cited as precedent in all manner of sources, ranging from the medical journals, legal journals, newspapers such as *The Times* and the *Evening Standard* to the minutes of the BMA's Central Ethical Committee.⁷⁰ These citations brought the importance of the Duchess's trial to the attention of medical and legal professionals as well as the wider public, and their importance should not be overlooked. For instance, the articles from the *Law Journal* and the *Solicitor's Journal* were picked up with some interest by the newly established Ministry of Health, and were included in their file on medical confidentiality in the early 1920s. Similarly, William Brend's article in the *BMJ* in early 1922, was cited in a special meeting of the BMA Council, held to discuss the question of medical confidentiality and became required reading for

⁶⁶ J Glaister, *A Textbook of Medical Jurisprudence and Toxicology*, 2nd ed. (Edinburgh, 1910), 44. This information is replicated in the following editions of Glaister's book.

⁶⁷ *BMJ* 4th & 18th April 1896.

⁶⁸ Public Record Office, Kew, HO 45/9988/X72989, General Medical Council memorandum for Home Office on question of medical confidentiality, 18 January 1899.

⁶⁹ *BMJ* 11 March 1899.

⁷⁰ The following is by no means an exhaustive list of citations of the Duchess precedent: *Garner v Garner*, *The Times Law Reports* vol. 36, 196; *Needham v Needham*, *Daily Chronicle*, 10 June 1921; *BMJ* 24 April 1920, 14 January 1922, 9 October & 13 November 1926; *Lancet* 1 April 1922; *Law Journal* 18 June 1921; *Solicitor's Journal* 24 January 1920; *The Times* 15 January 1920; *Evening Standard* 26 January 1922; British Medical Association, Central Ethical Committee minutes 9 November 1920 & 15 December 1921.

members of the BMA's professional secrecy committee before its first meeting in March of that year.⁷¹

Unwitting as it was, the lasting legacy of a Duchess who courted controversy was the legal implications of her trial for bigamy, including its impact on the determination of medical privilege. On a fundamental level the case illustrates many points relating to the issue of medical confidentiality. The conflict between private life and public interest is evident, as is the controversy over the frontier that divides them. Professional and personal interests, observed in the actions of both Hawkins and Berkley, are also prominent in the trial, and it is clear that confidentiality was firmly grounded in the concept of honour. Attention has also been drawn to differences in the method and manner of the court's treatment of the petitions from Hawkins, Barrington, and Berkley, observing in particular the leniency of the approach to Barrington and the confirmation of the legal privilege with Berkley. Yet, the response of the court to each of the challenges must be seen as only half the story. As Frevert notes in an examination of honour in duelling

Securing victory over their opponents was not the main concern of eighteenth-century duellistsIt was not the outcome of the duel which determined whether or not the duellists were men of honour, but the fact that the duel was staged at all.⁷²

By challenging such an authoritative court on a point of law, each of the witnesses desired the recognition that they were in a position to do so, and be taken seriously. The courtroom duels were fought for honour, prestige, personal and professional interest, all of which could be maintained in the act of the challenge as much as in the outcome itself. In this sensational case of private agendas and personal interests, is to be found the precedent that bound the whole of an evolving medical profession on the issue of medical confidentiality.

⁷¹ *BMJ* 14 January 1922, 64-66.

⁷² U Frevert, *Men of Honour. A Social and Cultural History of the Duel*, (Cambridge, 1995), 13.

Chapter 3 – The Long Nineteenth Century

The Duchess of Kingston's trial was far from a full discussion of the delineation of medical confidentiality. Nonetheless, it was adopted as an important legal precedent for the boundaries of medical confidentiality. The authority of the House of Lords, coupled with Hawkins's elite status as Serjeant-Surgeon to the King, and rise to the ranks of the baronetcy, were significant contributory factors in the binding nature of the precedent on the whole of medical practice. Yet, it is necessary to examine further, why a decision made in haste in a court with such a prominent bias towards social prestige and honour should have had as lasting an impact on medical confidentiality as Mansfield's decision in the Duchess of Kingston trial. For, while little had changed by the turn of the twentieth century with regard to medical privilege in court, other key developments in the practice of medicine meant there were new strains being put on the confidentiality of the doctor-patient relationship outwith the witness-box.

Perhaps the most obvious of the changes from the late eighteenth century was the emergence of an identifiable medical *profession* during the nineteenth century. The Royal College of Physicians' attempt to re-assert the rigidity of the three-tiered hierarchy in medicine through its intervention in the Apothecaries Act of 1815 proved an insufficient ballast against the tide of change that was steadily washing away the physician / surgeon / apothecary hierarchy and replacing it with a new distinction between consultant and general practitioner.¹ The significance of this change has been drawn out by Ivan Waddington in a series of works relating to the nineteenth century professionalisation of medicine and the development of modern day medical ethics. The blurring of the boundaries between each of the spheres of medical practice, in the competitive context of a largely unregulated medical marketplace led to friction between medical practitioners. Waddington cites numerous examples of tension, confusion and outright hostility in the interaction of medical practitioners in the first half of the nineteenth century, a problem rooted in the confusion of far-reaching

¹ See I Waddington, 'General Practitioners and Consultants in Early Nineteenth-Century England: The Sociology of an Intra-Professional Conflict', in J Woodward and D Richards (eds.), *Health Care and Popular Medicine in Nineteenth Century England*, (London, 1977), 164-188; and I Waddington, *The Medical Profession in the Industrial Revolution*, (Dublin, 1984), part 1, 1-49.

change: an ongoing clash of old against new, of those whose self-interest lay in maintaining the status quo and those whose self-interest required change.

The importance of this conflict and tension for the matter of medical confidentiality was essentially two-fold. In the first instance it meant that the main focus of medical ethics at the time was the relationships between medical practitioners themselves rather than between the medical profession and its clients. In his work on the development of modern day codes of medical ethics, Waddington is clear that, in the first half of the nineteenth century, medical ethics were firmly focussed on the problem of practitioners' conduct towards one another.² The profession that was meant to be caring for others was gaining a reputation for hostility amongst its own members. It is in this context that writers, most notably Thomas Percival in his *Medical Ethics* of 1803, produced works which sought to remedy the maladies so evident within intra-professional medical relationships. Waddington notes that Percival's 1803 text, a revamped version of a book entitled *Medical jurisprudence* written in 1794, was a reaction to a dispute during a typhus/typhoid outbreak at the Manchester Infirmary in 1789. The hospital had been inundated with cases to such an extent that the trustees had doubled the medical staff, much to the chagrin of the existing practitioners. Seeing the action as a reflection on their efforts the original staff resigned their posts. Percival's work was therefore commissioned to deal with the obvious problem of intra-professional behaviour, and gave only fleeting consideration to the doctor-client relationship. Moreover, Percival's book was not unique, and Waddington cites numerous other writers, as well as articles which regularly appeared in the medical journals, all of which emphasised the need for more cohesion and understanding amongst medical practitioners.³ Thus, following Waddington's line of thought, it is apparent that a partial explanation of the longevity of Mansfield's decision in the Duchess of Kingston's case, at least from the medical profession's point of view, is to be found in the primary need to sort out the problem of internal division in practitioners' relations before the focus could be turned on matters which concerned medicine's interaction with other parties, be they patients or the law.

² I Waddington, 'The Development of Medical Ethics – A Sociological Analysis', in *Medical History*, 1975, 19, 36-51; I Waddington, *The Medical Profession in the Industrial Revolution*, chapter 8.

³ Ibid.

The second, and not unrelated, consequence of the internal tensions of early nineteenth century medicine was a move towards greater regulation of medical practice. This desire was largely born out of a perception of the medical marketplace as overcrowded by the 1830s, a situation inflamed by the open and direct competition between *bona fide* practitioners (those with education or training) and the unqualified. This was a key factor in the prolonged drive for statute legislation to regulate medical practice in the mid-nineteenth century, culminating initially in the 1858 Medical Act. Waddington's argument, far from seeing the regulation of medical practice as motivated by practitioners' desire to protect the interests and well-being of the unwitting public, emphasises the economic benefit which would accrue to registered practitioners in a marketplace where state regulation gave them a monopoly on practice. Thus self-interest drove the reform of medical practice, and the regulation of medicine through fixed standards of professional entry qualifications and disciplinary hearings for misconduct were essentially the guise which passed off selfishness as altruism. The role of the 1858 Act in defining the framework for the modern day medical profession has been well documented, along with the prolonged battle between general practitioners and the Royal Colleges in the lead up to it. The resultant legislation may have been more suited to the old school of thought advocated by the elite amongst the Royal College of Physicians and Royal College of Surgeons, but it nonetheless proved to be a significant first step in the complex evolution of the modern day medical profession.

However, Waddington's interpretation of Percival's work as purely etiquette and his discarding of 19th century medical ethics as a self-interested scheme by which qualified practitioners could monopolise the overcrowded marketplace have come in for severe criticism by medical historians. On the latter of these points, Robert Baker notes that Waddington's strong monopolisation argument relies on 19th century medical practice taking place in a free market. However the ignorance of the consumer (patient) and the fact that the vendor (medical practitioner), in order to survive financially, was always forced to sell meant that in reality the market place was not free.⁴ Baker further criticises Waddington for engaging a discount rule whereby any historical accounts which failed to fit in with the theory of professionalisation which Waddington propounded were discarded. Far from being a

⁴ R Baker, 'Introduction', *The codification of medical morality*, vol.2, (Dordrecht, 1995), 11-12.

self-interested attempt to delude themselves or the public, Baker argues that contemporary accounts show evidence that medical practitioners who advocated legislative regulation of medical practice were aware of the confluence of professional, societal and individual interest.⁵ Thus, what Baker terms the 'ultra weak' monopolisation theory recognises self-interest as a conjoint concern of the medical profession.

Waddington's other main concern with Percival's work was the supposed absence of issues relating to the interaction between the profession and society. Chester Burns, while not denying the primacy of intra-professional relationships in Percival's work, notes that Percival additionally drew out the doctor's social obligations not only in public health but also his duty to the law, including medical testimony in court.⁶ This point was further developed in the writings of Michael Ryan in the 1830s, who saw the need for medical practitioners to understand the moral and legal responsibility which community expectations could place on them through the embodiment of collective opinion in statute law. Judicial decision could override the traditions which the profession promoted amongst its members, and, as Anne Crowther notes, in the absence of a widely accepted modern day code of ethics the medical profession looked to the law for guidance.⁷ The law prevailed over professional ethics. Yet, as the example of Glaister's writings on abortion (discussed later in this chapter) show, the law was not always consistent. Practitioners could turn to their textbooks of medical jurisprudence seeking ethical guidance, but what they found there often obscured rather than clarified correct practice.

Important off-shoots of the battle between GPs and consultants over the terms of the 1858 Medical Act were the development of medical journals and societies specifically designed to express the views of the majority of medical practitioners who worked in general practice. Having been set up as the Provincial Medical and Surgical Association, the British Medical Association, as it came to be known from the mid-1850s onwards, was to become an immensely powerful organisation, representing and protecting the main body of the medical profession. Sub-committees such as the central ethical committee were set up to look at specific issues of

⁵ Ibid. 17.

⁶ C Burns, 'Reciprocity in the development of Anglo-American medical ethics, 1765-1865', in R Baker (ed), *The codification of medical morality*, vol.2, (Dordrecht, 1995), 137.

⁷ M A Crowther, 'Forensic medicine and medical ethics in nineteenth-century Britain', in R Baker (ed), *The codification of medical morality*, vol.2, (Dordrecht, 1995), 173-190.

controversy such as medical confidentiality. Perhaps the most effective mouthpiece of the GP's position in the run-up to the Medical Act of 1858 was Thomas Wakley's medical journal the *Lancet*. Wakley, both as a medical practitioner and as an MP, was a highly outspoken advocate of medical reform, focussing in particular on the need for greater recognition of general practitioners as well as reform in the education and regulation of practice as a whole. In Porter's words, Wakley

Battled to raise medicine into a respected profession, with structured, regulated entry and lofty ethical ideals – called restrictive practices by their foes.⁸

The need for general practitioners - the majority of the profession - to have an effective voice in the ongoing debates on the development of medicine, led to the growth of, and a growing influence for, medical journals and associations.

Professional identity was further fostered by the increased centralisation of medical education throughout the nineteenth century. Unlike Scotland which already had an established tradition of university medical education, in England the steady shift away from the personal educational relationship of master and apprentice towards the more centralised hospital medical schools, and later universities, gave practitioners a growing sense of shared experience and identity. Large numbers of students received their education and sense of professional values from the same, relatively small number of, medical school teachers. In Waddington's words:

As a result of these changes in the structure of medical education medical students underwent a new and more intensive process of professional socialisation that both fostered a sense of professional community and asserted the primacy of professional rather than lay values.⁹

Defining values for a rapidly changing profession was not going to be an overnight process. The 1858 Act established the General Council for Medical Education and Registration with the remit of establishing a register of all qualified medical practitioners. A single register containing the names of all those qualified to practise

⁸ R Porter, *The greatest benefit to mankind* (London, 1997), 351.

⁹ I Waddington, 'The movement towards the professionalisation of medicine', in *BMJ* 1990; 690.

medicine was a significant step in the establishment of a unified profession, giving *bona fide* practitioners their long sought after recognition, and competitive advantage, over the unqualified in the medical marketplace.

Section 29 of the 1858 Act provided the General Medical Council (as it came to be known) with the power to hold disciplinary inquiries into the professional conduct of practitioners and to remove from the register the names of those who were judged to have been guilty of infamous conduct in a professional respect. It therefore naturally lends itself as a prime candidate for examination as a body which set and maintained guidelines of professional practice in medicine, including the issue of medical confidentiality. Unfortunately, as Russell Smith's examination of the GMC shows, the matter is somewhat more complex.¹⁰ After initial teething problems, the GMC set-up an adversarial, quasi-legal, system of hearings to decide allegations of professional misconduct. The members of the GMC who heard and decided cases were all medically trained, though they had recourse to legal opinion. As such the body could have represented a significant prescriptive force in the self-regulation of the relatively new and still evolving medical profession. In the event, it faced many problems in getting beyond the role of a reactionary system of discipline in individual cases.

Although its decisions were published in the medical press after 1864 (prior to that decisions had only been made known to GMC members), the GMC did not give reasons for, or explanations of, decisions. Partly because of this, the committee did not adhere to the doctrine of precedent meaning that each new case was decided in isolation. This, coupled with the facts that decisions were given extempore and that decision-makers changed frequently, did not promote the discernment of consistent rules. Clearly the *ad hoc* reporting of *ad hoc* decisions minus their explanatory basis was not a satisfactory way to inform practitioners of how to avoid allegations of professional misconduct. The GMC did issue declarations of acceptable standards of professional conduct which it arrived at by distilling what it perceived as the relevant ethical principles from a series of disciplinary decisions in cases of a similar nature. While this sounds good in theory, the aforementioned factors entailed problems for its implementation in practice. As Smith indicates:

¹⁰ R G Smith, 'The development of ethical guidance for medical practitioners by the General Medical Council', *Medical History*, 1993, 37, 56-67.

there was often a considerable lapse of time between the initial hearing of disciplinary cases relating to a particular matter and the appearance of the GMC's Warning Notice with respect to any given issue.¹¹

Of the 13 issues of conduct which Smith considers, the most pronounced gap belongs to 'breach of confidence'. The first inquiry about, and erasure from the medical register for, this transgression arrived before the GMC on the 5 July 1869. The GMC issued its first guidelines on the question on the 24 November 1970, over 101 years later.¹² Clearly then, while the GMC may provide some information on cases heard for breach of confidence, it was not a source of guidance on the question of medical confidentiality to which medical practitioners could readily turn in the late nineteenth and early twentieth centuries.

However, the GMC was not unique in experiencing difficulty in trying to establish general guidance on the issue of confidentiality. The law courts themselves were sending mixed signals. As noted in the previous chapter, Mansfield's ruling in the Duchess's case had drawn disapproval from certain later judges, notably Buller in *Wilson v Rastall*, 1792 and Lord Chancellor Brougham in *Greenough v Gaskell*, 1838. Such dissent had not faded away by the late nineteenth century. In his summing up in *Kitson v Playfair*, 1896, Hawkins belittled the relevance of the rules which the medical profession laid down for their own guidance on medical confidentiality. There could be no absolute rule, even (taking into account judicial discretion) with regard to giving evidence in court: 'each case must be considered by its own particular circumstances, and by the ruling of the judge who happened to preside on the occasion.'¹³ Clearly this left room for divergence of judicial opinion and confusion for medical practitioners as to where the law stood. Glaister picked up on this point towards the end of the section on confidentiality in his early twentieth century textbook of medical jurisprudence. Citing Hawkins's stated belief that it would be a 'monstrous cruelty' for a medical practitioner to report to the public prosecutor a woman who had sought medical attention as a result of procuring an abortion, Glaister noted how this point of view conflicted with that given by Lord Justice-Clerk Inglis in the Pritchard poisoning case of 1865. Dr Paterson was called to

¹¹ Ibid. 62.

¹² Ibid.

¹³ Justice Hawkins words as summed up in: J Glaister, *Glaister's Medical Jurisprudence and Toxicology*, 6th ed. (Edinburgh, 1938), 51.

attend the wife of a colleague, Dr Pritchard. On examination, Paterson felt it possible that she was being poisoned, but decided it was not his professional duty to disclose his suspicions to the police. Mrs Pritchard subsequently died. Dr Pritchard was found guilty of poisoning his wife and was executed on Glasgow Green in front of an estimated crowd of 100,000 people. This was the last public execution in Scotland.¹⁴ In reprimanding Paterson for his failure to notify the relevant authorities of his suspicion that Mrs Pritchard was being poisoned, Inglis emphasised the primacy of the doctor's duty as a citizen to prevent the destruction of human life over the rules of professional etiquette which frowned on breach of confidence. Thus both Hawkins and Inglis had made quite clear their belief in the supremacy of the law over professional ideals of correct conduct, but arrived at contradictory conclusions. Glaister was left to surmise:

These two opinions expressed by these high criminal judges demand the serious attention of the medical profession, although it is difficult, if not, indeed, impossible, to reconcile the two views.¹⁵

The examples themselves bring to light another key factor in the development of medicine and its relation to confidentiality in nineteenth century Britain: the increasing role of the state in medical affairs. Porter suggests that pervasive state intervention in medical activities did not arrive in Britain until the twentieth century, but if the nineteenth century state concern for public health was somewhat more *ad hoc*, its influence on medical confidentiality was not inconsiderable.¹⁶ The Common Lodging Houses Acts of 1851 and 1853 compelled the proprietor of a lodging house, on pain of a 40s fine, to notify the authorities if a resident showed signs of an infectious disease.¹⁷ Through the Contagious Diseases Acts of 1864, 1866, and 1869 the state had designated policing duties to the medical profession, giving them the

¹⁴ L Farmer, 'Notable Trials and the Criminal Law in Scotland and England, 1750-1950' in Ph Chassaing and J P Genet (eds.), *Droit et société en France et en Grande-Bretagne (12-20 siècles). Fonctions, usages et représentations*, (Paris, 2003), 149.

¹⁵ Ibid. 53.

¹⁶ R Porter, *The greatest benefit to mankind*, 351.

¹⁷ G Mooney, 'Public health versus private practice: the contested development of compulsory infectious disease notification in late nineteenth century Britain', *Bulletin of the History of Medicine*, 1999, 73, 241.

authority for 'the forcible medical examination'¹⁸ of prostitutes and the power to confine those with VD for up to three months. The Acts aimed to maintain order and control at dockyard and garrison towns, but as Lawrence notes:

Although there was a powerful medical lobby which viewed the Acts as progressive extensions of public health legislation, many doctors considered them a gross infringement of individual rights.¹⁹

Medicine, as dystopian writers of the twentieth century would emphasise, could be used as a powerful tool for social control, but medical practitioners were not always compliant.²⁰ The problem was one of priorities: the doctor's foremost duty had traditionally been to the patient but increasingly the collective interest of public health was challenging for the limelight. As one medical officer of health noted in 1866, the traditional ethic of the general practitioner which put duty to the patient first, the patient's family second and public concern thereafter, was exactly reversed in the priorities of the doctors employed in the newly prominent field of public health.²¹

Although the Contagious Disease Acts, having met with stiff opposition, were repealed a decade later, the state, in recognition of the benefits of a healthy workforce, and, after the panic surrounding the physical deficiencies of conscripts for the Boer War, the need for a healthy armed force, had renewed interest in public health. Whereas public health reformers of the mid-nineteenth century had sought to improve the environment of the poorer classes, by the late nineteenth and early twentieth century much emphasis was being placed on theories of genetic inheritance to improve the nation's stock. Drawing on Mendel's work on genetic characteristics in plants, Darwin's theory of species evolution, and Galton's biometrics (the application of statistical techniques to biological phenomena), the social hygiene movement and later eugenics became significant forces advocating the application of scientific

¹⁸ G Savage, 'The willful communication of a loathsome disease': marital conflict and venereal disease in Victorian England', *Victorian Studies*, 35, 1990.

¹⁹ C Lawrence, *Medicine in the making of modern Britain, 1700-1920*, (London, 1994), 61.

²⁰ An obvious example of the literary representation of this point can be found in E Zamiatan, *We*, in B G Guerney (ed), *An anthology of Russian literature in the Soviet period from Gorki to Pasternak*, (New York, 1960) 163-353, where medical men, as channels of state control, use operations to 'cure' fantasy in the population (p.308), but a medical practitioner plays a significant role in the resistance movement (p.237-240).

²¹ John Sykes as quoted in G Mooney, 'Public health versus private practice', 256.

principles to social and political life.²² Social hygienists believed that a greater understanding of how positive characteristics were passed on from one generation to the next, and the statistical probabilities of characteristic inheritance in humans would lead to an improvement in the well-being of the British population. Advocates of eugenics saw the problem in more urgent terms, believing that national efficiency and the purity of the British race required, at least, the promotion of childbearing amongst the better-off (and thereby inherently superior) classes of society, a belief termed 'positive' eugenics. Their more sinister counterparts, the 'negative' eugenicists focussed on the need to prevent the inferior members of society, the poor or disabled, from diluting the purity of the race with their offspring. Common to eugenics and social hygiene alike was the need for information about the population. Middle class reformers, organised into voluntary and charitable societies focussed on the poor, held investigation and regulation, medical inspection and control, as the keys to national efficiency, giving Britain economic and military competitiveness with the other European powers in the years prior to the First World War.²³ The collective was the primary concern and the submission of the individual, particularly the 'poor' individual, to scrutiny and analysis was a necessary evil. Eugenics, while not being without considerable political influence on both left and right wing thought, did not achieve the dominance of political life which certain of its advocates predicted.²⁴ Nonetheless, the importance of the nation's collective health was not lost on the powers governing the state.

Legislation such as the Infectious Disease (Notification) Act 1889, and the Notification of Births Act 1909 (with an amending Act in 1915) required medical practitioners to override the confidentiality of their patients in order to notify the medical officer of health for their district in cases of infectious disease (a list of those diseases which qualified was issued, though there were ongoing debates about whether VD and other maladies should be added), or the birth of a child. The individual consciences of practitioners were to be sidelined by the levying of fines in cases where the relevant disease (or death under the Births and Deaths Registration Act 1874) was not notified, and assuaged by the benefit of a small financial fee for

²² G Searle, *Eugenics and politics in Britain, 1900-1914*, (Leyden, 1976), 3-8.

²³ G Jones, *Social hygiene in twentieth century Britain*, (London, 1986), 10 and 17.

²⁴ R Porter, *The greatest benefit to mankind*, 640; G Searle, *Eugenics and politics in Britain*, 67.

every case of birth notified. Simple economics would help circumvent practitioners' moral reticence in overriding patient confidentiality.

The BMA did officially support the principle of compulsory notification of infectious disease, primarily for its pivotal role in combating the outbreak of epidemics. Nonetheless, in recognition of the long-held importance of confidentiality to the doctor-patient relationship, the BMA advocated that legislation should place the onus on the householder rather than the medical attendant to notify the authorities of infectious disease. Mooney argues that accompanying their belief in the importance of confidentiality, general practitioners also wished to defend the right of the individual against the state.²⁵ Moreover, many feared that notification, along with compulsory removal of the diseased to hospital, would deter individuals from seeking official medical assistance. Not only would such reluctance to gain medical assistance be detrimental to public health, but it would also deprive medical practitioners of income from call-outs and follow-up visits. Therefore notification was recognised as both essential for the checking of epidemics, and as a potential deterrent for patients. Practitioners recognised the benefit that public health accrued from early information on the spread of infection, but simultaneously wished to safeguard their long-held ethic of confidentiality and the right of the individual to be free from state interference. So, while the state rattled practitioners' pockets through the levying of fines for failure to notify or the paying of small sums for compliance, the thought that potential fees could be lost through patients' reluctance to call in medical assistance for fear of notification, and the absence of follow-up visits to those isolated in hospital, meant even self-interest led to quandary.

It was not solely in the motives for action or the projected outcomes that practitioners were pulled in opposing directions. The laws themselves were sufficiently open to interpretation to envelop practitioners in grey areas of subjective judgement. For instance, infectious disease did not have to be notified if the victims could be sufficiently well isolated in their own accommodation. Despite having an obvious bias to the better-off in society, the law was open to interpretation as to what constituted adequate accommodation for quarantine. The law was malleable enough to be moulded to suit circumstance and status – a point perhaps most evident in connection with the statutes relating to abortion. The only operation to be decreed

²⁵ G Mooney, 'Public health versus private practice', 256.

criminal by statute law, abortion was a mosaic of public and private opinions and agendas. In Barbara Brookes' words:

The legitimacy of abortion as a solution to an unwanted pregnancy was judged differently according to the circumstances of conception, the age and status of the mother and the eugenic 'value' of the foetus...It was not then, abortion itself which brought universal censure, but rather particular social classifications of the act.²⁶

From the state's point of view the decline in the birth rate in the late nineteenth century was a significant factor in its policy on abortion, notably its increased pressure on medical practitioners to notify cases that came to their attention. In this sense the doctor's dilemma was similar to that posed by infectious disease notification with the conflicting priorities of duty to the individual and to the state clearly evident. However, while infectious diseases put the rest of the population at immediate risk, abortion could and did remain a far more private affair, seen by many as a crime without a victim, carried out by consenting women.²⁷

The permutations of the act of abortion were numerous: the pregnant woman could attempt it herself either using instruments, such as knitting needles, easily at her disposal or purchasing a purgative remedy; she could have an operation, defined in the loosest sense of the term, carried out by almost anyone from a friend to a professional abortionist; or she could turn to mainstream medicine which was permitted to carry out therapeutic abortions in order to protect the well-being of the mother, a rather ill-defined and easily exploited loophole. It was the law which, unwittingly, simplified the situation for medical practitioners, distinguishing which cases of abortion they were likely to notify. In attempting to deter women from abortion by the imposition of excessively heavy penalties for those convicted of the crime, the law actually succeeded in deterring medical practitioners from turning-in women, often perceived as having suffered sufficiently already, to further humiliation and ruin at the hands of the law. The one clear exception to this was in cases where the pregnant woman died as a result of an attempted abortion. In such cases the profession saw the duty to notify in more black and white terms, recognising the

²⁶ B Brookes, *Abortion in England 1900-1967* (London, 1988), 7-9.

²⁷ *Ibid.* 34.

benefit of bringing the abortionist to justice in order to protect others in the future. However, as the case of Annie Hodgkiss (discussed later in this chapter) confirmed, the constant threat that a patient would die suddenly, left practitioners who followed such a policy walking a somewhat precarious tightrope.

Legislative obligations aside, the changing form of medical employment was having an impact upon medical confidentiality. As Porter indicates, a cohort of doctors emerged whose primary interest in preventive, rather than curative, medicine entailed a concern for the population in general rather than for individual clients - a situation that had the potential to pull medical practitioners in opposing directions:

The prison doctor was implicated in a punitive regime, but ethically his duty lay with the well-being of the individual convict. A similar predicament was involved with workmen's compensation schemes for industrial accidents and illness.²⁸

Employment of medical practitioners by someone other than the patients themselves naturally led to an increasingly complex moral maze of obligation and duty towards employer, patient, professional reputation and, particularly after the National Insurance Act of 1911, the State. The medical journals had their columns filled with practitioner enquiries as to the appropriate procedure to be followed in situations where the right course seemed unclear.²⁹

Yet, as the columns of the medical journals show, while the question of medical confidentiality was caught up in a range of different issues, it seems that the most pressing by the late nineteenth century was that of criminal abortion. Beneath a query as to the best cycling saddle for a lady, the *BMJ* published a letter received from a young doctor in late May 1896, which sought advice as to his duty in a case of criminal abortion which had come before him.³⁰ The woman, who confessed that her miscarriage had been induced by use of an instrument, had been in a critical condition but was presently on the mend. The practitioner wished to know if he was obliged to report the crime. The journal's response indicated that the matter had already been

²⁸ R Porter, *The Greatest Benefit to Mankind*, 636.

²⁹ For queries relating to practitioners obligation *vis-à-vis* employers & employees see for example: *BMJ*, 1896, vol.2, 698 'Professional confidence'; *BMJ*, 1899, vol.1, 950 'Professional secrecy'; *BMJ*, 1899, vol.2, 1652 'Privilege as to medical certificates.'

³⁰ *BMJ*, 1896, vol.1, 1367. 'Professional secrecy.'

discussed, but ‘we apprehend that it has not been finally decided, especially in view of the opinion stated to have been given to the College of Physicians by their legal adviser.’³¹

Unlike the best bicycle saddle for a lady (the Brookes B.30), the *BMJ* was experiencing problems in giving clear and definitive advice in response to practitioner concerns on the notification of abortion. Before going on to examine why the questions surrounding abortion were causing so much concern, it is worth pausing to note that the individual, E B Turner, assigned the task of trying out ladies’ bicycle saddles in 1896 was a solicitor to the BMA. He became heavily involved with the question of medical confidentiality, eventually becoming legal adviser to the BMA Professional Secrecy Committee from its inception in 1922.

Under the Offences Against the Person Act of 1861, the law of England had established severe penalties for women and any accomplice who procured an illegal abortion. In Scotland, the same punitive view, although not endorsed by statute, was recognised in common law. John Glaister’s examination of the medico-legal risks encountered by practitioners in the course of their daily work in the late nineteenth century leaves the reader in no doubt of a medical practitioner’s vulnerability to legal action. The ease with which claims could be brought against doctors by patients or fellow practitioners was a problem exacerbated by the difficulty of disproving any accusations. Any charge would almost certainly damage a practitioner’s reputation and finances, but as Glaister notes, it could prove far more serious:

an old and much respected practitioner in Kensington, named Haffenden... was apprehended and charged at the police court with criminally procuring abortion...from the mental anxiety arising out of the ruinous nature of the charge, [he] committed suicide by poison, although in the last document he penned during his life he declared his innocence....the jury, after an absence of six minutes, gave a verdict of “not guilty”.³²

Until the time of *Kitson v Playfair*, in Glaister’s opinion, the law was generally understood by medical practitioners to impose on them a duty to notify the relevant

³¹ Ibid.

³² J Glaister, ‘Medico-legal risks encountered by medical practitioners in the practice of their profession’, reprinted from the *Glasgow Medical Journal*, September 1886, 1-2.

authorities of cases in which abortion was suspected or had been brought to their attention. However, the statement by Hawkins, noted above, had 'traversed that understanding.'³³ As the fates of Haffenden and Playfair had so definitively demonstrated, dubiety in the understanding and practice of the law of notification could have serious consequences. In recognition of this, the whole question of criminal abortion and its notification, including Hawkins's remarks, were brought for discussion before the Royal College of Physicians of London. In 1895-6 the Royal College of Physicians set up a committee to investigate the medical practitioner's duty in relation to criminal abortion. At their instance, legal opinion was taken from Sir Edward Clarke (1841-1931) and Horace Avory (1851-1935).

Clarke was a pre-eminent common law Queen's Counsel and was MP for Plymouth from 1880-1900. He was appointed solicitor-general in 1886 and held the post until the fall of Lord Salisbury's government in 1892. When Salisbury returned to power in 1895, Clarke turned down the position of solicitor-general in order to continue in private practice. In 1897 he declined an offer to become Master of the Rolls as it would have precluded him from taking any part in politics. In contrast to Clarke's esteemed position within the law, Avory was still building his legal career. Having 'devilled' for Clarke as a junior counsel, Avory rose through the legal ranks to become King's Counsel in 1901. By 1910 he was a judge on the King's Bench division of the High Court – a position he was to use to challenge the medical profession's traditional view of confidentiality in 1914.

The opinions of Clarke and Avory constituted a large part of the report on the doctor's duty to notify abortion presented to the Royal College of Physicians on 30 April 1896. The discussion focused on two main areas where members of the Royal College of Physicians seemed to have felt the correct course of action was not clear. In the first instance, they wished to clarify when the act of procuring abortion was lawful. What, for instance, was to be done in a case where a pregnant woman's life was at risk unless her pregnancy was terminated? Would abortion in this instance be legal, and, if not, would the doctor be held responsible for the resulting death of the mother? This point was dealt with quite briefly by Clarke and Avory, who stated that in their opinion the law did not forbid abortion during pregnancy or the destruction of the child during labour where it was necessary to save the mother's life.

³³ J Glaister, *Glaister's Medical Jurisprudence and Toxicology*, 6th ed. (Edinburgh, 1938), 358.

The second, and altogether more complex, matter requiring clarification was what the medical practitioner's duty was once he suspected, or was made aware of a case of criminal abortion. The question could be subdivided. Would a medical practitioner lay himself open to being charged as an accessory to the crime if he gave medical aid to a post-abortion woman? The crime tarred as felons both the person who carried out the act and the woman who solicited it. Thus, by knowingly aiding a patient who was unwell as a result of a criminal abortion, a practitioner could feasibly be brought up on a charge of being an accessory to the crime. Would a doctor be liable to indictment for misprision of felony if he did not report the crime? 'Misprision of felony' was the concealment of a crime committed by another, but without such previous knowledge or subsequent assistance of the criminal as would make the party concealing an accessory before or after the fact. The crime was becoming obsolete by the early twentieth century. Finally, did the doctor have any privilege with regard to secrets confided in him by patients?

Taking the questions in order, Clarke and Avory stated that, in their opinion, a medical practitioner did not render himself liable as an accessory if he treated a patient whom he knew, or suspected, had been party to a criminal abortion, provided he did nothing to assist the patient from escaping from or defeating justice. This seems a strangely inadequate statement, for presumably the ends of justice required that the medical practitioner notified the authorities that a criminal act had taken place, yet no mention of this course of action is made by the two legal figures. The physician's duty was simply to treat the patient to the best of his skill and not assist her from escaping or defeating justice. With regard to misprision of felony, the medical practitioner was not liable merely because he did not give information in a case where he suspected criminal abortion. In a case where a practitioner was told by a patient the name of someone she was about to go to in order to have an abortion carried out, Clarke and Avory thought that the medical practitioner had a duty to warn the person, presumably meaning the named individual, that such a statement had been made.

These answers appear highly unsatisfactory in clearing up the issues raised. The question that was put to Clarke and Avory asked specifically what duty lay on the medical practitioner who suspected criminal abortion had been procured. To say that a medical man should tend to a patient he believed to have been party to a criminal abortion seems entirely in keeping with a humane justice system. It would be

improper for an ill woman's health, or life, to rest upon the single opinion of a medical practitioner as to whether or not she had committed a crime. In that scenario the doctor would be simultaneously judge, jury and executioner. Rather, justice required that the process should be based on evidence collected and discussed before the legal system, whose obligation and purpose was to establish the criminality or otherwise of the act. However, Clarke and Avory gave no indication that a duty lay with a doctor to notify the law where abortion was suspected. Rather, they suggested that a doctor who treated a post-abortion woman without notifying the police would not be likely to face a charge of misprision of felony. Moreover, if a doctor became aware that a colleague was about to carry out a criminal abortion he should inform the colleague that he was aware of the fact. The Royal College of Physicians could only be left with the impression that their members should carry out abortions, before or during birth, where the mother's life was at risk; medically treat, but in no other way assist, women who came to them after a criminal abortion; and that they were under no obligation to notify the law.³⁴

To their question on medical privilege, the Royal College of Physicians received a straightforward rejection of the idea of an existing medical privilege. In response to a request as to how to go about getting a change in the law on privilege, Clarke and Avory suggested that if they were right in the views they had expressed, no alteration of the law would probably be desired. Their general advice was that medical practitioners should exercise their own discretion as to when information should be given in particular cases. The doctor should follow his conscience.

These opinions are important, not least because they represent a specific consultation of legal opinion by the RCP on the question of confidentiality at the turn of the twentieth century, but also because they were referred to by Professor Robert Saundby in his early twentieth century work *Medical Ethics: A Guide to Professional Conduct*. Saundby was an ex-chairman of both the BMA council and of its central ethical committee; in 1912 he was elected to the GMC as a direct representative of the profession. In *Medical Ethics*, Saundby related the opinions expressed by Avory and Clarke in their consultation with the RCP as being

³⁴ This last point was raised by Saundby in 1915, during his analysis of Clarke and Avory's opinions expressed before the Royal College of Physicians in 1896.

to the effect that a medical man should not reveal facts which had come to his knowledge in the course of his professional duties, even in so extreme a case as where there are grounds to suspect that a criminal offence had been committed.³⁵

Avory was at the centre of a controversy which brought the issue to prominence once again at the end of 1914.³⁶ Sitting as judge at the Birmingham Assizes on 1 December 1914 he was forced to throw out a case against Annie Hodgkiss, accused of the manslaughter of Ellen Armstrong on whom Hodgkiss was alleged to have performed an illegal abortion. Armstrong, a young unmarried woman whose family had been patients of Dr A for some time, was taken ill and admitted to the Birmingham Women's Hospital. Dr A visited Armstrong in hospital. During the visit Armstrong told Dr A that she had had an abortion and gave the name of the woman who had performed it. She explicitly asked Dr A not to tell anyone, a promise which Dr A considered binding. Armstrong subsequently, and very abruptly, died of a haemorrhage. Having carefully gone through the papers connected with the case, Avory was forced to state that in the absence of evidence the jury was advised to find no true bill. In addressing the jury, Avory made it quite clear that he believed that the opinion he had expressed along with Clarke in 1896 had been misrepresented in Saundby's textbook on medical ethics. The implication was that, in the case before him, he felt that there had been a failure on the part of Dr A to perform the duty which society had a right to expect from a medical practitioner placed in such circumstances, and notify the authorities.

This opinion was picked up by Sir Charles Mathews, Director of Public Prosecutions who wrote to Hempson, solicitor to the BMA on 14 December 1914.³⁷ He requested that Avory's views be given wide circulation amongst the medical profession in order that they might correct the inaccuracy of Saundby's book.³⁸ If Mathews expected his letter would be met with deferential compliance, he was forced to reconsider. Hempson's prompt reply noted that Avory's views were not in

³⁵ R Saundby, *Medical Ethics: A Guide to Professional Conduct*, 2nd ed. (London, 1907), 114.

³⁶ See *Lancet* December 19th, 1914. Article entitled 'Medicine and the law. A Judge on professional secrecy.'

³⁷ Sir Charles Mathews (1850-1920) was Director of Public Prosecutions from 1909 until his death in 1920.

³⁸ This letter and the following correspondence between Mathews and Hempson are all contained in the BMA CEC Minutes for 1914/15.

accordance with other decisions which had been passed down from the Bench at various times, notably in *Kitson v Playfair*. Hempson indicated that the general question involved was 'of the highest importance to the medical profession and is far-reaching in point of principle.' He suggested that authoritative guidance was required and that the body which held the respect of the profession in such matters was the central ethical committee of the BMA, to whom Hempson was legal adviser. With Mathews' permission (their correspondence having been clearly marked 'Personal') he could raise the matter for discussion by that committee.

Mathews assented to this suggestion, with one major proviso. As far as possible, discussion of the question of medical secrecy in relation to abortion should be kept out of the press in order to avoid controversy.³⁹ In his own words:

what I should deprecate would be a press controversy upon the subject to which men of eminence in the medical profession might become contributors, and in which they might announce themselves as entirely differing from the views of Mr Justice Avory, and as declining to be bound by them.⁴⁰

It is not surprising that the Director of Public Prosecutions would advise against the sparking of a press controversy in which eminent physicians may have been inclined to lead a rebellion against the law. It is also of little surprise that Hempson was not able to give even an implied guarantee that the topic could be entirely withheld from the medical press.⁴¹ Both sides foresaw the far-reaching implications of the question of medical confidentiality and the potential for direct conflict over the issue. The law wished to keep direct challenges to their authority out of the public gaze, but Mathews also recognised the difficulty with which the justice system would be faced if it lost the ability to command medical evidence. Acting on behalf of the medical profession, Hempson was aware that popular opinion would be a strong factor in establishing their position, and that public support would be crucial if any challenge to the law was to be contemplated. After further correspondence, it was agreed that a meeting between Hempson and Mathews would be held to discuss the matter.⁴²

³⁹ Mathews to Hempson, 17 December 1914.

⁴⁰ Ibid.

⁴¹ Hempson to Mathews, 18 December 1914.

⁴² Mathews to Hempson, 19 December 1914 and Hempson to Mathews 21 December 1914.

This meeting took place on 22 December 1914 at Whitehall. Hempson made it clear that he did not believe Avory's views would be met with approval or compliance by the medical profession. In response, Mathews indicated that there could be no support for practitioners who claimed that statements made to them by patients should be held to be inviolable. Simply put, doctors 'were citizens of the State, [and] that as such they owed a higher duty to the State in aid of the suppression of crime than to their patient'.⁴³ Mathews conceded that solicitors, barristers and ministers of religion were not under obligation to disclose information, and that they were not subject to the same imposed duty as he contended attached to the medical profession. Hempson enquired whether the state proposed to offer protection to medical men, who disclosed information when required in accordance with their proposed public duty, from any civil proceedings which might be brought against them by patients. Mathews was reluctant to commit himself on this issue, but he 'obviously recognised that such obligation of protection would not be assumed by the State.'⁴⁴ Hempson suggested that once the BMA had given the matter its due consideration, a deputation could meet with some high state official, such as the secretary of state for the Home Department, in order to obtain an authoritative ruling on the point. He reiterated that Avory's dictum did not receive support from certain other legal authorities of an equal or higher standing, a challenge which Mathews conceded. However, Mathews confided in Hempson that the Lord Chief Justice (Rufus Isaacs, Lord Reading) had considered and approved the decision of Avory, and that, as Chief Coroner of England and Wales, he proposed that a copy of Avory's views, bearing the mark of his confirmatory approval, should be sent to every coroner in England and Wales as 'a guiding light as to the attitude which it was their duty to adopt should similar cases arise at any inquest before them.'⁴⁵ Hempson must have been left with the impression that, while contradictory decisions had been handed down by judges in the past, there was a growing uniformity of opinion amongst key legal figures that medical practitioners should be made aware of their ultimate duty to the state and their necessary contribution to the ends of justice.

Having been given permission to bring the question of medical confidentiality, as raised by Avory, before the central ethical committee of the BMA, Hempson

⁴³ Taken from Mr Hempson's note on his meeting with the Director of Public Prosecutions, 22nd December, 1914. BMA CEC Minutes, 1914/15.

⁴⁴ Ibid.

⁴⁵ Ibid.

arranged a meeting for 8 January 1915. In light of the fact that much of Avory's criticism of the medical profession had focused on Saundby's supposed misrepresentation of the views expressed during the consultation with the Royal College of Physicians in 1895, Saundby was invited to attend the meeting. This he was unable to do, but sent in his place a memorandum he had written on the subject, which he intended to submit for publication in the *BMJ* but was currently withholding pending the consideration of the matter by the Royal College of Physicians. His memorandum had been read and approved by both Dr A, the key medical attendant in the case over which Avory had presided, and the honorary surgeon of the hospital in which the patient had died.

Referring back to the consultation that had taken place between the Royal College of Physicians and Clarke and Avory, Saundby's memorandum reiterated the difficult position medical men found themselves in with regard to their duty in relation to the 'unfortunately frequent' crime of abortion. He contended that the legal opinion stated by Clarke and Avory omitted all reference to any obligation to communicate with the police and therefore

they may be said not unfairly to have given ground for inference that in their opinion no such obligation exists, for otherwise they surely should have included it in their statement of his duty.⁴⁶

This seems a fair point to make. As noted above, the question which had been put to Clarke and Avory had explicitly requested advice on the duty of the medical practitioner, who knew or believed he was in attendance upon a case where criminal abortion had been procured. To say that a doctor should treat the woman to the best of his skill and do nothing to aid her from escaping justice, without explicitly stating that he had a firm duty to inform the authorities that a criminal act had taken place, does seem to have left the door wide open to the interpretation which Saundby made. Indeed, if Clarke and Avory's answer had not conveyed this impression to its audience, but rather intended being an avoidance of the fundamental question, presumably such an obvious omission would have been picked-up by the RCP who were anxious to have greater clarity on this complex and far-reaching problem.

⁴⁶ Saundby's Memorandum as contained in the BMA CEC Minutes 8 January 1915.

Saundby's memorandum indicated that the medical profession was disposed to draw a general distinction between cases in which the patient recovered or was expected to do so; and cases where death resulted or was likely to do so as a result of an illegal operation. In the former instance, the profession was 'indisposed to break the implied bond of professional secrecy'⁴⁷, whilst, in the latter, there was a recognised duty to help in securing that a crime with such serious consequences did not go unpunished. In acknowledgement of the apparent lack of consistency in this position, Saundby suggested that justification was found in the medical practitioner's desire to avoid the scandal which would be brought upon the patient and her family if he were to report every case of criminal abortion which came to his attention. Significantly, he enforced this justification by stating his belief that public opinion not only supported such an attitude but would be 'shocked and outraged' were the practitioner to act in another manner. Any change to this view would have to be brought about through fresh legislation, sanctioned by public opinion.

Saundby acknowledged that by making such a distinction in practice it was inevitable that there would be cases in which the death of a patient whom the doctor had believed would recover, would occur so suddenly as to leave no time for a dying deposition to take place. Indeed these were the circumstances of the case over which Avory had presided, and which sparked his tirade against the profession. Yet, Saundby believed such injustice as occurred in these cases could only be seen as an unfortunate consequence which could neither be blamed on the medical practitioner acting under the existing circumstances, nor be done away with until public opinion had changed. Those who read Saundby's memorandum must have been struck by two key points. The distinction between notifying cases of criminal abortion in cases where the patient was likely to die and non-notification where the patient was likely to recover, while acknowledged as imperfect, would require legislation to change it. Moreover, such legislation would require the backing of public opinion, which in Saundby's view firmly supported the position adopted by medical practitioners.

Although Saundby was unable to attend the meeting of the central ethical committee, the 'importance of the subject'⁴⁸ led the chairman, Reginal Langdon-Down, to request the BMA solicitor, Hempson, to attend. His opinions were recorded

⁴⁷ Ibid.

⁴⁸ BMA CEC Minutes, 1914/15. Phrase used in a letter from James Neal, Deputy Medical Secretary to the BMA to members of the Central Ethical Committee, 1 January 1915.

in a draft memorandum prepared pursuant to the meeting of January 8 1915, by James Neal, the BMA Deputy Medical Secretary. Hempson explained that solicitors and barristers had an absolute privilege of protection with regard to statements made to them in their professional capacity, and that, by custom, courts normally recognised protection for ministers of religion. However, no other class of persons was accorded such protection by state authority or Act of Parliament. In the case of medical practitioners, Hempson reiterated the point he had put to Mathews, namely, that there was a conflict of authority on the matter. Quoting from Hawkins' ruling in *Kitson v Playfair*, Hempson noted that while this decision had given a clear indication that medical men were not to go running to the authorities in every case of illegal abortion, it was contended in 'certain quarters'⁴⁹ that medical men, as citizens of the state, owed a higher duty to the state in the detection of crime, than to their own patients. Presumably the 'certain quarters' was a reference to Hempson's prior meeting with Mathews.

Neal's memorandum made clear the central ethical committee's stance on this apparent dichotomy. In the absence of state protection for doctors who found themselves subjected to civil proceedings as a result of notifying a case of suspected illegal abortion which was subsequently judged to be untrue, and the prospect of resultant high damages – the £12,000 damages initially awarded against Playfair was an ominous precedent - the committee felt that the state could not reasonably claim that a medical practitioner had an obligation to breach patient confidentiality without the patient's consent. Furthermore, the committee drew attention to the ill consequences that any departure from the 'usual custom of regarding the confidences of a patient as sacred'⁵⁰ would have by deterring the general public from seeking medical aid. Any person who had been involved in a criminal act would not be able to seek medical attention for fear of personal incrimination.

As a result of its discussions, the committee made three recommendations to the BMA council. No information should be given under any circumstances without patient consent. In the absence of protection for doctors from the possible legal consequences of disclosure, the state had no authority to claim that doctors were obliged to disclose patient information. As well as ventilating the question in the

⁴⁹ BMA CEC Minutes, 1914/15. Point 8 of the Draft Memorandum from the Central Ethical Committee meeting 8 January 1915.

⁵⁰ Ibid. Point 11.

BMJ, the final resolution proposed sending a copy of the resolutions to the appropriate Department of State.⁵¹ In light of the committee's knowledge of the stance advocated by both the Director of Public Prosecutions and the Lord Chief Justice, its proposals were a sign of defiance. Any suggestion that the BMA council might reject or dilute such confrontational recommendations was quashed by its adoption of them in an amended form on 27 January 1915. Far from acting in a conciliatory manner, the council's only amendment was the removal of the conditional from the second resolution. This deletion implied that the BMA was not simply looking to protect its members' interests by seeking state protection from financial damages arising from civil proceedings against them. It was clearly stating that the medical profession took very seriously the long established duty of confidentiality and would not give it up without a fight.⁵²

Not content with internally focused sabre-rattling, the council openly pronounced its position in the final resolution. What could have been more confrontational than sending a copy of a resolution denying state authority over the medical profession with regard to notification of illegal abortion to the relevant state department? Surely the answer to that was the deliberate ventilation of the whole question in the medical journals against the expressed wishes of the Director of Public Prosecutions. The gauntlet thrown down, initially by Ivory and then by Mathews, had been firmly taken up by the BMA central ethical committee and council who clearly had no intention of pulling their punches.

In addition to the above decisions, the council passed a resolution empowering the central ethical committee to take 'any further action considered desirable'⁵³ including sending a deputation to the appropriate state department. By mid March, Hempson was able to report that he had had another meeting with Mathews in order to discuss the letters which had been sent to the Lord Chief Justice and the Home Secretary by instruction of the council at the end of January. As a result of this meeting, it was quite possible that the BMA would be asked to send representatives to

⁵¹ Ibid. Point 12. The first two recommendations came to be known, and are later referred to, as Minutes 542 and 550 respectively.

⁵² The content that was removed from the second resolution was reiterated in an amendment to Point 9 of the Draft Memorandum of the CEC meeting 8 January 1915. It read: "The Committee is advised that no obligation rests upon the medical practitioner voluntarily to disclose the confidence of his patient without the patient's consent. It suggests that, if the State desires to set up such an obligation, it should at the very least preface such an endeavour by affording to the practitioner protection from any legal consequences that may result from his action."

⁵³ BMA CEC Minutes, 1914/15. 19 February 1915.

meet the Law Officers of the Crown and that the Royal College of Physicians and the Royal College of Surgeons might also be involved in such a meeting. Hempson indicated that he had given Mathews an undertaking that, for the time being, no correspondence should appear in the *BMJ* on the matter. It is thus increasingly apparent that open discussion of the issue of confidentiality was being strongly resisted in high legal quarters. At their first meeting, Hempson had made it quite clear to Mathews that not even an implied guarantee could be given that a subject of such magnitude could be kept out of the press. Moreover the central ethical committee and council had both made it clear that the matter required ventilation in the medical press at the very least. It can only be assumed that undertaking not to publish correspondence on professional secrecy in the *BMJ* was a prerequisite to being granted a meeting with some high state officials in order to discuss the matter. Again it seems clear that the law was trying to keep the issue away from the public gaze, and was forcing the medical profession to comply with its wishes by discussing it in private.⁵⁴

The central ethical committee recommended that any deputation sent to the Law Officers of the Crown on this matter should consist of the chairman of representative meetings, chairman of council, treasurer, the chairman and deputy chairman of the central ethical committee, the medical secretary, deputy medical secretary and the solicitor. In short, a high ranking slice of the BMA. It further recommended that if the two Royal Colleges were also invited to send deputations to the Law Officers, then a prior meeting between the Colleges' representatives and the BMA deputation should be arranged. Consensus of opinion and unity of approach would be significant assets if any serious challenge to legal authority was to be made.

In fact it was a deputation from the BMA alone which met with the Lord Chief Justice, the Attorney-General, the Public Prosecutor and other legal authorities on 3 May 1915. With a defensive qualification that no observation made by the Lord Chief Justice during the meeting could be taken as a judicial pronouncement of the law, the Law Officers reiterated their assertion that doctors had a duty to notify cases of abortion. This rule was subject to three limitations. The doctor had to be of the opinion, either from examination of the patient or because of a communication from

⁵⁴ The only article in which the issue of confidentiality / professional secrecy was discussed in the *BMJ* of that year was 'Supplementary Report of Council 1914-1915' in the *BMJ* 3rd July 1915, Supplement, 4.

the patient, that abortion had been attempted or procured by artificial intervention; the intervention had to have been carried out by someone other than the patient herself; and the doctor had to believe that the woman was likely to die as a result of the abortion and that 'there was no hope of her ultimate recovery.'⁵⁵

Anxious to have clarity on the matter, the central ethical committee had the wording of the above three limitations approved by the Lord Chief Justice in a meeting with Hempson on 11 May 1915. Once again, there was an explicit request from the legal side that no publication of the matter in the press or the *BMJ* should be made, as the Lord Chief Justice did not wish the question to be openly discussed until something definite had been arrived at or until he had given his sanction to it being publicly known. In fact, the Lord Chief Justice's views were published as part of the supplementary report of council in the *BMJ* supplement of 3 July 1915.⁵⁶ The Lord Chief Justice was informed that the BMA wished to include his statements in their report of council and that this would entail a discussion of the subject at the forthcoming annual representatives' meeting in July. The central ethical committee stressed that the BMA had no desire to open any further debate of the matter but they had to respond to the remarks of Avory at the Birmingham Assizes. The law could not very well provoke discussion and then demand that the medical profession give no open response.

In their meeting on 28 May, the central ethical committee also noted a letter which had been received from the registrar of the GMC, indicating that he had received a communication from Mathews relating to the notification, by medical men to the police, of illegal operations. Mathews had made reference to the resolutions which had been formulated by the BMA, and the president of the GMC requested a copy of these and any other relevant information for the GMC executive committee's consideration. With interest in the subject snowballing, it was again agreed that the Royal College of Physicians and the Royal College of Surgeons should be approached in order that a meeting of representatives could discuss the duties of medical men in relation to criminal abortion.

On 10 June, the council of the Royal College of Surgeons passed a resolution indicating that, as they had already considered the matter and sent a reply to Mathews, they could ~~see~~ see no advantage in the proposed conference. Their reply to the BMA

⁵⁵ BMA CEC Minutes 1914/15. 28th May 1915.

⁵⁶ Cf. Footnote 62.

included a copy of their letter to Mathews. This letter gave a clear indication that they could not concur with the opinions expressed by Avory, not least because they were not given as the basis of a judicial decision. The Royal College of Surgeons had never defined the doctor-patient relationship but it had always recognised that complete confidence between doctor and patient was essential in the treatment of disease. In their opinion, it was fortunate that such confidence nearly always existed and was of incalculable advantage to the patient and the public. No written rules could have any binding effect in what they termed a matter of 'honour and conscience'⁵⁷ and ultimately the conduct of each medical practitioner had to be decided by his own conscience and sense of duty to his patient and to the state. The letter concluded that the rarity of complaints as to the conduct of medical practitioners in criminal cases *vis-à-vis* the frequency with which they were involved in them indicated that there was no need to attempt to frame rules for the guidance of fellows and members of the Royal College of Surgeons on such questions. 'The Council believe that in the future, as in the past, the course to be taken can safely be left to the medical practitioner.'⁵⁸ The honourable physician and his conscience were, usually, the best judge of each situation.

On 15 June, the Royal College of Physicians, having had the matter under consideration by its censor's board since the remarks of Avory had been brought to their attention by Mathews in early January, discussed the BMA proposal for a meeting. During the meeting it passed five resolutions. The first iterated that each medical practitioner had a moral obligation to secrecy which could not be breached without patient consent. The second and third together stated that doctors should urge a patient suffering the ill-effects of an illegal abortion to give evidence against the abortionist. This was especially advisable in cases where the patient was likely to die. If, however, she refused, the doctor was 'under no obligation (so the college is advised) to take further action.'⁵⁹ This gives an indication that Clarke and Avory had left the Royal College of Physicians with the belief that they had no absolute obligation to notify criminal abortion. The remaining two resolutions recommended that doctors should obtain the best possible medical and legal advice both to ensure the validity of any evidence a patient might give but also to protect the doctor from

⁵⁷ BMA CEC Minutes, 1914/15. RCS to Director of Public Prosecutions, 2 July 1915.

⁵⁸ Ibid.

⁵⁹ BMA CEC Minutes, 1914/15. RCP to BMA, 2 July 1915.

subsequent litigation; and that, if a patient should die in circumstances where criminal abortion was suspected, the doctor should refuse to issue a death certificate but communicate with the coroner. Having expressed the position as they saw it, and acknowledged that they were looking to obtain further legal advice on confidentiality in relation to criminal abortion, the Royal College of Physicians did not see any need for a meeting with the BMA and the Royal College of Surgeons.

Thus, it was quite clear by mid-1915, that Avory's remarks at the Birmingham Assizes in 1914 had sparked discussion of the question of medical confidentiality amongst key bodies of the medical profession, each of which had independently come to the conclusion that they could not concur with his point of view. No general meeting of these medical bodies materialised, although their opinions were shared through confidential correspondence. With legal opinion, in the form of the Lord Chief Justice and Director of Public Prosecutions, firmly in support of Avory, and pedantically opposed to any general discussion of the matter in the lay or medical press, the whole situation reached a hiatus in terms of institutional interaction by the end of July 1915. To an extent this is probably attributable to the disruption caused by the First World War which engaged the full attention of the BMA who undertook to organize medical provision for the war effort. Andrew Morrice suggests that the medical profession were victorious in the stand-off over medical confidentiality in 1915.⁶⁰ If so, it was more by default – throwing the last punch before the bell sounded for the end of the round - than because of any convincing argument they made. While medical confidentiality was more or less sidelined as an issue as the war enveloped attention, the stated differences between legal and medical opinion on the relative merits of the doctor's duty to the patient and to the state, pointed towards a resumption of the contest in the near future.

The only other record of the issue arising in the BMA central ethical committee minutes for 1915, was a letter received from the assistant secretary of the Renfrewshire panel committee informing the BMA that a recent case in the Inner House of the Court of Session (the supreme court of Scotland) had considered the question of privileged communications made to a Roman Catholic priest. The case concerned a paternity dispute in which one of the parties had made a statement to the priest, and while the sheriff substitute (county court judge) who originally heard the

⁶⁰ Morrice, 'Should the doctor tell? Medical secrecy in early twentieth-century Britain.'

case had decided in favour of a priestly privilege, the Court of Session reversed his judgement. This point would have been of great interest to the CEC, for not only did it illustrate that the question of confidentiality was being more generally probed, but also any argument for medical privilege would be more akin to that which had been customarily given to ministers of religion than to the privilege accorded to solicitors and barristers. The committee requested that they be informed when the case was published in the law reports.

The publication of the report of the Royal Commission on venereal disease in 1916, brought new issues to be contemplated by the central ethical committee. Paragraph 205 of the report recommended that the law should be amended to allow that a communication made *bona fide* by a medical practitioner to a parent, guardian or other person directly interested in the welfare of a woman, or man, with the intention of delaying or preventing them from marrying a person with an infectious form of VD, should be treated as a privileged communication. Significantly, this proposal had the support of the President of the Probate Division.⁶¹ The parliamentary subcommittee of the BMA medico-political committee asked the central ethical committee to consider the implications of paragraph 205 in relation to their previous consideration of the question of medical confidentiality. The central ethical committee concluded that in light of council minutes 542 and 550 of January 27 1915, it was 'very strongly' of the opinion that medical practitioners could not make such disclosures as were contemplated in paragraph 205 of the royal commission report without the consent of the patient.⁶² Furthermore, no amendment to the law which would allow such a communication to be privileged was required 'unless and until the duty of making such communications is imposed on medical practitioners as a statutory obligation.'⁶³ The council adopted the central ethical committee's recommendations on this matter and passed a resolution indicating that it would be left to the chairman of the council to include a reference to the decision in the report which was to be submitted to the annual representatives meeting for 1916. This he

⁶¹ *Royal Commission on Venereal Diseases. Final Report of the Commissioners*, (London: His Majesty's Stationery Office, 1916), para. 205.

⁶² BMA CEC Minutes, 1914/15. 6 June 1916.

⁶³ *Ibid.*

did, and an amended version of the recommendation was put as a substantive motion to the 1916 meeting.⁶⁴ The resolution was lost.

Not all matters that were brought before the attention of the central ethical committee required such careful deliberation. A letter received from the general secretary of the order “Achei Birth” and “Shield of Abraham” Grand Lodge on the 22 November 1916 asked the committee for clarification regarding the confidentiality of communications made between the secretary of a society and a doctor. Though not explicitly marked so, letters sent by the general secretary to a doctor regarding a member of the Society, had always been treated as confidential, in keeping with the relationship of doctor and patient. However, one doctor had not taken this view of matters, much to the chagrin of the society who requested the opinion of the central ethical committee. Their reply was abrupt. The matter could hardly be considered a question of medical ethics, and any difficulty could be circumvented by marking the letters “Private and Confidential”.⁶⁵

An interesting letter was received on 4 June 1918.⁶⁶ Captain G H Grant Davie wished to have verified his contention that a patient had a right to consult her medical adviser as to whether or not she was suffering from VD, and, if found to be clean, was entitled to request a medical certificate to that effect. The doctor could not reasonably refuse to issue the certificate and no question of the moral or immoral use to which any such certificate might be put entered into the relationship between a patient seeking confirmation of her physical state and her medical adviser. The central ethical committee agreed entirely with the contentions made by Davie. The significance of this example is to be found in the committee’s desire to distance the medical practitioner from the question of morality. By confirming Davie’s viewpoint, they were drawing a clear line between the strictly functional role of the medic in examining and issuing a certificate, and any role he may adopt, or be assigned, as a moral guardian in society. This distinction was to be repeatedly challenged over the coming years by the increasing prevalence of VD, and the accompanying debate over the priority of preventive or curative measures to combat it.

⁶⁴ The amended version read as follows: “That in the opinion of the RB no amendment of the law to provide that a communication such as is contemplated in Recommendation 25 of the Royal Commission on Venereal Disease shall be privileged is called for.”

⁶⁵ BMA CEC Minutes 1914/15. 24 November 1916.

⁶⁶ BMA CEC Minutes, 1914/15. 8 October 1918.

The following month, the issue of medical confidentiality was raised in connection with farm labourers' wages. Dr X from the Oxford division of the BMA wrote explaining that he had been requested by a local farmer to provide medical certificates for two labourers on his farm.⁶⁷ One was aged 72 and had atheromatous arteries and was getting infirm, while the other was 54 and suffered from mitral disease. For these reasons the farmer wanted medical certificates in order to justify him not paying them the minimum weekly wage of 30s. The committee's response stated that the certificates could only be passed on if the labourers, with full knowledge of the purpose for which they would be used, gave their consent. This opinion was firmly in keeping with Council Minute 542, passed at the start of 1915, but it also inherently extended it. Whereas Minute 542 placed the emphasis on no communication without the patient's consent, the committee's reply to Dr X clearly accentuated the need for *informed* consent.

The question of abortion had by no means gone away. The Honorary Secretary of the Sheffield division wrote to the BMA in June 1918, seeking advice relative to her being summoned to give evidence in Court.⁶⁸ In 1917, she attended a woman who had suffered a miscarriage in the seventh month of her pregnancy, and had returned to see her earlier in 1918 when she was again ill as a result of miscarriage, this time in the 3rd or 4th month. Criminal abortion was suspected in both cases. The CEC suggested that when she was asked by the court to disclose information which she had obtained in the exercise of her professional duties she should protest that she could not betray the professional confidence of her patient. She should then be guided by the directions of the magistrate or judge. In light of the frequency with which such queries, cases and almost identical advice would arise over subsequent years, this short paragraph in the CEC minutes assumes an altogether more pivotal importance than the committee could ever have suspected.

In summary then, the nineteenth century was a period of far-reaching change for medical practitioners. The professionalisation of medicine through developments in centralised education, the founding of medical journals and the BMA and the establishment, under the 1858 Medical Act, of the GMC with its authority to maintain a single register of qualified practitioners, meant that by the early twentieth century the issue of medical confidentiality could be addressed by a more unified and

⁶⁷ Ibid.

⁶⁸ Ibid.

cohesive body of practitioners. Medical ethics had evolved, in the first half of the nineteenth century, predominantly, though not exclusively, as a means to regulate intra-professional conflict in the confusion and tension of rapid changes in practice in an unregulated marketplace. After the establishment of the GMC with its power to hold disciplinary hearings and remove practitioners from the *Medical Register*, medicine had the beginnings of a system of effective professional self-regulation and prescriptive advice on professional conduct. As noted, for medical confidentiality at least, the GMC's approach was far from perfect and practitioners were still faced with contradiction and confusion on the correct action to be taken with regard to many ethical dilemmas. This point was equally true when it came to judicial interpretations of the law. The decisions of Hawkins and Inglis sent conflicting signals to practitioners about their duty as citizens of the state and their actions as human beings. The uncertainty of leaving decisions up to the individual doctor meant that on the one hand practitioners were left unprotected from proceedings against them in cases where someone they had accused of performing an illegal operation was found not guilty, while on the other, they received condemnation from legal authorities for their perceived failure to do their duty as citizens when they did not notify the authorities. Failure to notify deaths could cost practitioners relatively small fines; questioning the honour of a middle class lady, as William Smoult Playfair discovered, could cost £12,000; and a false allegation of procuring abortion could cost a practitioner his reputation, his income or, in the case of Haffenden, his life.

State intervention in medicine had placed medical men in a pivotal role in public health through notification acts and, post 1911, partially state-funded health care. The rise in the number of situations in which medical men were employed by someone other than the patient they were directly treating led to confusion for practitioners as to where their obligation lay. The medical journals attempted to respond to questions about the disclosing of medical information about employees to their employers; whether a prospective bride should be forewarned of her fiancé's contagious VD; or what to do in cases of suspected abortion. Such complex problems, by dint of the recognized importance of the particulars of each case, did not easily permit of standardized advice. As with the GMC rulings and the legal opinions, the effect produced was uncertainty for medical practitioners.

Lord Mansfield's decision in the Duchess of Kingston case distinguished between information demanded in court and breach of confidence outwith the witness

box. While there was no change in the practitioner's duty to give evidence in court, the nineteenth century saw an extension of the law's demands on doctors as the state tightened its grip on them as public servants of general welfare and justice. However, practitioners still largely remained individual competitors in a challenging marketplace. Herein lay the crux of the conflict. While the state and the desired elevation of medicine into a lofty profession pulled practitioners towards the general good; tradition and the competitive marketplace clung on to them and held their focus on the individual interests of both patient and practitioner. State interest in the collective would need more than fines and small fees to change doctors' long-held belief in the primacy of their duty to the patient. As the law so frequently reminded, doctors had duties as citizens of the state, but as many practitioners were all too aware: citizens they may be, employees they were not.

It is clear from the above that the question of medical confidentiality was an important one in the early twentieth century, involving high status individuals and interest groups. Avory who triggered debate in late 1914, had been involved in the consultation with the Royal College of Physicians in 1895-6. The interpretation of his remarks by Saundby's textbook drew severe criticism from legal quarters. The attempts by the Director of Public Prosecutions, with the informal support of the Lord Chief Justice, to cajole the medical profession into putting duty to the state above duty to the patient, were met with opposition by each of the medical bodies approached: the BMA, the Royal College of Surgeons, and the Royal College of Physicians. Although no meeting took place between these three bodies, it is clear that they did communicate their relative opinions to each other, and there was further institutional interaction when BMA representatives met with the Lord Chief Justice, Attorney-General, Public Prosecutor and other legal authorities to discuss the question in May 1915. The strong desire by the legal side of the debate to keep the matter out of the press, and the initial disregard with which the BMA treated this, is worthy of note, when it is considered that both sides claimed to be acting in the interests, or with the support, of the public.

The hiatus in institutional interaction on the question by mid-1915 did not equate to a definitive resolution of the question. The CEC minutes record that the question continued to arise in subsequent months and years. Although professional secrecy was involved in matters ranging from the payment of farm labourers' wages to the admission of individuals to mother and child homes, the issues of criminal

abortion and VD recurred time and again. While abortion had been most prominent in the 1895-6 and 1914-15 discussions, the early interwar years, examined in the next chapter, was the period when medical confidentiality in connection with VD started to dominate.

Introduction to the Early Interwar Years Section

The early interwar years provide the highpoint in the debate over medical confidentiality. This is largely due to the involvement of three powerful interest groups: the Ministry of Health, the British Medical Association and the judiciary (represented by Lord Chancellor Birkenhead). Each group's involvement stemmed from one key problem - the judiciary's demand that doctors from VD clinics give evidence in divorce hearings. The Ministry of Health was responsible for these clinics and had pledged that all treatment would be confidential. However, the judicial system was inundated with divorce petitions in the immediate post-war years, and the Lord Chancellor was reluctant to relinquish the courts' right to demand medical evidence. The two central figures – Christopher Addison (Minister for Health) and Birkenhead (Lord Chancellor) - came from opposite sides of the coalition government. Addison was a Liberal intent on promoting social welfare legislation, while Birkenhead was a staunch Conservative. The British Medical Association, having established itself as a key voice of the medical profession, sought to use the interest in the question to challenge the law on medical privilege. The following three chapters are intended to show how the question developed within each group.

Chapter 4 - The Ministry of Health

“Truth, like all other good things, may be loved unwisely, may be pursued too keenly, may cost too much.”¹

The Ministry of Health, established in 1919, was a symbol of state interest in the welfare of the post-war population.² Dr Christopher Addison, the first Minister of Health was a staunch promoter of a social welfare agenda within Lloyd George’s coalition government, including a highly ambitious scheme of slum clearance and house construction. Addison owed much of his political progress to his close links with Lloyd George whom he had helped out by using his medical background to secure sufficient medical support to allow Lloyd George to implement his National Insurance scheme prior to the First World War. In addition to Addison’s wartime experience at the Ministries of Munitions and Reconstruction, the nascent Ministry of Health had the ‘formidable administrative team’³ of Sir Robert Morant as permanent secretary and Sir George Newman as chief medical officer; as well as the ‘outstanding civil servant’⁴ Sir John Anderson as second secretary.

Medically trained, Newman took the M.D. at Edinburgh in 1895 the same year in which he received a diploma in public health from Cambridge. His keen interest in public health resulted in his appointment as chief medical officer to the Board of Education’s newly established school medical service in 1907. Here he developed an early working relationship with Morant whilst drawing up plans for the medical inspection of schoolchildren. Newman also served on a number of health-related committees during the war before becoming chief medical officer of health in 1919 – a post he held until 1935. Robert Morant had been permanent secretary of the Board of Education from 1903 until leaving to become chairman of the National Health Insurance Commission in 1911. Therefore, he had considerable experience in government interaction with the medical profession prior to his appointment as permanent secretary at the Ministry of Health in 1919. The same can be said for

¹ Knight Bruce in *Pearse v Pearse* 1 De Gex & Sm, 28 29 as quoted in PRO MH78/ 253 Addison to Birkenhead 3 June 1920.

² The Ministry of Health will hereafter be referred to as the ‘Ministry’.

³ K Morgan and J Morgan, *Portrait of a Progressive. The Political Career of Christopher, Viscount Addison*, (Oxford, 1980), 94.

⁴ *Ibid.* 102.

Anderson who was secretary of the National Health Insurance Commission from 1913 until he moved to the Ministry of Shipping in 1917. He became additional secretary to the Local Government Board in March 1919 and to the Ministry of Health when it took over the responsibilities of the Local Government Board in July 1919. Though formidable, Addison, Newman, Morant and Anderson did not last long as an administrative unit. In October 1919, Anderson moved to become chairman of the Inland Revenue. His absence was heightened by the death of Morant in March 1920. Almost exactly a year later, Addison himself was moved to become Minister without Portfolio. Obviously, the loss of such experienced personnel did not help the nascent Ministry of Health in its attempts to challenge the law over medical privilege.

In taking over the Local Government Board's responsibilities, the Ministry inherited the VD treatment scheme complete with the pledge of confidentiality given in the 1916 VD regulations. Thus, while the Ministry's concern for public health normally entailed the breach of confidentiality in order to gather statistics or isolate cases of infectious disease, in the case of VD it had a vested interest in protecting medical confidentiality. It was this which made it liable to be sucked into the debate over the boundaries of medical confidentiality.

The Ministry's attention was first drawn to the question of medical confidentiality by a series of letters querying the legal position of doctors when asked to disclose information at a patient's request. This situation most frequently arose with VD medical officers, whose testimony regarding the presence or transmission of VD could benefit their patients in divorce proceedings. In late October 1919, Colonel Bolam from the VD treatment centre at Newcastle-upon-Tyne Royal Victoria Infirmary. Bolam was also chairman of the BMA council, a direct representative on the GMC and a member of the consultative council of the Ministry, but does not give any indication that he was writing in any of these official capacities. He indicated that a number of awkward medico-legal questions were arising relative to the disclosure of information about patients attending VD clinics, and suggested that a definite plan was needed for dealing with such cases.⁵ The policy adopted by staff at the Newcastle hospital was not to disclose to any third party, either in writing or verbally, information relative to the patient.

⁵ PRO MH78/253 Bolam to Ministry of Health 28 Oct 1919.

Bolam's question related to the importance of confidentiality in the effort to combat VD as laid-out in the Public Health (Venereal Disease) Regulations 1916. Article II (2) of these regulations clearly stated that all proceedings at VD clinics were to be kept confidential. Dr. F J H Coutts, a senior medical officer in charge of the Ministry's work on tuberculosis and VD, referred Bolam's letter to Machlachlan, assistant secretary to the Ministry.⁶ The latter suggested that, although the breaking of confidence was to be done at the patient's request, this should not impact upon the doctor's duty under the 1916 regulations. Having drafted a letter along these lines, Machlachlan requested that the Ministry's legal adviser, Gwyer, review the position.⁷ Gwyer took the opposite view, interpreting the 1916 regulations as simply restating medical etiquette on the point. Etiquette would not impose any obligation upon the doctor to refrain from disclosing relevant medical information at the patient's request, indeed he noted that moral and social duty may require it of him.

Gwyer noted that the regulations could not override the law, which stated that any doctor subpoenaed to give evidence in court must answer all questions put to him, though he may appeal to the judge for exemption. He believed that 'most judges will take a reasonable line in such a case and not adhere too rigidly to the strict letter of the law.'⁸ This viewpoint would be subject to significant re-evaluation as test cases arose over the course of subsequent months. Gwyer suggested that ultimately there could be no hard and fast rule as to when confidentiality should be held inviolate. It was these opinions that formed the basis of Coutts' reply to Bolam in Newcastle. Recognising the growing importance of the interpretation of confidentiality under the VD regulations, Slator requested a further 50 copies of Coutts' letter be made and this essentially became the Ministry's panacea for queries on confidentiality in the months that followed. It was sent in response to a request, similar to Bolam's, from Arthur Griffiths, secretary to the East Suffolk and Ipswich Hospital on 17 November 1919; and again to Hubert Sumner, secretary to the Birmingham and Midland Hospital for skin and urinary diseases on 9 December 1919. In recognition of this it is worth quoting in full.

⁶ There were six Senior Medical Officers, each with responsibility for a sub-section of the Ministry's portfolio.

⁷ Maurice Linford Gwyer (1878-1952).

⁸ PRO MH78/253 Gwyer to Machlachlan 7 November 1919.

I have referred your letter of the 28th October to our legal adviser who is of the opinion that it is difficult to lay down any general rule for the guidance of the medical staff of Venereal Diseases Clinics. You are of course aware that the Public Health (Venereal Diseases) Regulations, 1916, provide that all information obtained in regard to any person treated under a scheme approved in pursuance of the regulations shall be regarded as confidential. This provision imposes an obligation on the medical officer not to disclose to third parties any facts which his examination of a patient brings to light, but a disclosure at the request of a patient would not constitute a breach of the regulations.

The question whether such a disclosure should be made in any particular case must depend on circumstances. Where a patient *bona fide* contemplates legal proceedings, or where legal proceedings have actually been begun, it would not be unreasonable for the doctor, when so requested by the patient, to indicate the nature of the evidence which he would be prepared to give, if subpoenaed for that purpose. He should always insist upon a subpoena for his own protection, and his evidence should be strictly confined to matters of fact, including such inferences as may legitimately be drawn from those facts.

The question whether the doctor should give a written statement to the patient's solicitors must depend on the facts of the case. Where these are complicated or obscure, it may not be unreasonable that the solicitors should be made aware what evidence the witness is prepared to give; and if they are not prepared to take the risk of calling a witness who has given them no proof of his evidence, a refusal on the part of the doctor might lead to a denial of justice to the patient. But written statements by the doctor should be the exception rather than the rule, and certificates should not be given in any case. They are inadmissible as evidence in legal proceedings and are clearly capable of abuse.

Our legal adviser is further of the opinion that the medical officer would be well advised to confine his disclosure of information, even though he has the patient's consent, to the patient's solicitors where proceedings have begun or are *bona fide* in contemplation, and to the parent or guardian in the case of a minor. The responsibility for making use of the information will then be on the person to whom it is communicated, and the doctor would of course in every

case take all reasonable precautions to satisfy himself that it is not required for any but proper and legitimate purposes.

If a medical officer is subpoenaed to give evidence against the interest of his patient he must of course answer all relevant questions put to him, but he may properly appeal to the court for protection if a question involves him in a conflict of duties.

I hope that the above may be of some assistance to you.⁹

While medical confidentiality had come to the Ministry's attention as an area of dubiety in 1919, the widespread reporting of the case of *Garner v Garner* in early 1920 pushed it into prominence on the Ministry's agenda.¹⁰ Articles in *The Times*, on 14 and 15 January, and in the *Morning Post* of 16 January, sparked activity at the Ministry. Clara Garner was seeking a divorce on grounds of adultery and cruelty. The transmission of VD from husband to wife could provide evidence for both these clauses if it could be shown that the husband had contracted VD from another woman (adultery) and then infected his wife (cruelty). With this in mind, Clara Garner had subpoenaed Dr Salomon Kadinsky of the Westminster hospital to give evidence on her behalf. Appearing in court, Kadinsky was reluctant to breach the government pledge of secrecy which stated that all VD treatment was to be regarded as strictly confidential. Before being sworn as a witness, he produced a note from the chairman of the house committee of the Westminster Hospital which cited the emphasis placed on secrecy by the government regulations on VD. The judge, Alfred McCardie, refused the protest, stating that 'in a Court of Justice there were "even higher considerations than those which prevailed with regard to the position of medical men."' ¹¹ Kadinsky took the oath and testified that Clara Garner suffered from syphilis.

Gwyer seems to have been the first to grasp the importance of the reporting of the case in *The Times*. Consistent with his earlier stance on the subject, he noted that the doctor had been summoned in order to give evidence on his patient's behalf. The question of confidentiality, therefore, arose along the same lines as before i.e. whether the VD regulations imposed an obligation on doctors not to disclose patient

⁹ PRO MH78/253 Coutts to Bolam 15 November 1919

¹⁰ *Garner v Garner* in *The Times Law Reports* vol.36, 196.

¹¹ *The Times* 14 January 1920.

information even at the patient's request. As Coutts' letter to Bolam made clear, the Ministry's interpretation of the regulations permitted disclosure at the patient's request. Sir George Newman, Chief Medical Officer at the Ministry, concurred with this view. He suggested that the leader in *The Times* had completely missed this point thereby wrongly stating that the government's VD treatment scheme was futile. In the paper's own words: 'the endeavours which have long been made to root out a hidden plague in the community must be allowed to rank among the pious futilities of the Government.'¹² Newman did note, however, that cases could arise in which a doctor was subpoenaed and compelled to give evidence contrary to the wishes or interests of his patient. No scheme for the treatment of VD could avoid this legal requirement.

While the line taken by the Ministry was consistent with McCardie's ruling in the *Garner v Garner* case, condemnation of the decision to compel the medical witness to disclose patient information came from legal quarters. In an article entitled 'Doctors and professional privilege', the *Solicitor's Journal* questioned whether McCardie should not have had the courage to override the many legal precedents of rejecting medical privilege in court. Not only, it argued, did the lack of privilege place medical practitioners in a very awkward position, but on grounds of public policy

it seems very undesirable that a doctor should be compelled to disclose facts about the health of a patient when the State has itself invited such patients to undergo treatment in one of its venereal hospitals under a solemn and well-advertised pledge of absolute secrecy.¹³

The article cited many cases in which privilege had been claimed, including the Duchess of Kingston's trial, and drew analogy with other professions whose members regularly received confidential information, notably lawyers and clergymen. Instances, in which the latter were not compelled to give evidence by dint of judicial discretion, were highlighted as being closely analogous to the treatment that doctors should receive. The piece ended with an indication that 'now wider safeguards than that seem desirable.'¹⁴

¹² Ibid.

¹³ *Solicitor's Journal* 24 January 1920.

¹⁴ Ibid.

In the aftermath of *The Times*' controversial slant on the McCardie ruling and its impact on the efficacy of the government's VD treatment scheme, it was Gwyer who was first to suggest a solution. He proposed that a letter, intended to clear up the 'misapprehension' of McCardie's decision, should be circulated to the VD clinics and treatment centres. Newman agreed, and recommended that copies should be sent to all county and county borough councils and inserted in the press. A letter was drafted for this purpose, predominantly by Gwyer, and a copy of it was sent to Alfred Cox, Medical Secretary to the BMA, for comment. The accompanying note, signed by Sir Robert Morant, iterated the Ministry's belief that such a letter was required to counter the potential harm that the press coverage of *Garner v Garner* had caused. He suggested that the BMA, with whom 'I am most anxious that this Ministry should always work in touch,'¹⁵ would probably have a committee already looking into the issue, and any comments they had would be welcomed.

Cox's reply indicated that the BMA had already had the matter under consideration on a number of occasions, notably when a deputation met with the Lord Chief Justice, Home Secretary, Solicitor-General and Public Prosecutor in 1915. This collective of legal and political opinion had tried to convince the BMA deputation of the important duty upon medical men, as citizens, to disclose information about suspected criminal practices. However, the deputation had 'stoutly resisted' the proposal to use doctors as private detectives, arguing instead for a form of medical privilege to be granted. Cox indicated the general support of the BMA, and the specific backing of Dr Langdon-Down, chairman of its Central Ethical Committee, to the Ministry's proposed letter being inserted in the medical press. Cox was also supportive of the suggestion that Addison might bring the matter to the broader attention of the government.¹⁶

The time delay involved in this correspondence raised a question as to whether the insertion of a letter in the press would unnecessarily re-open and publicise the matter. Morant believed that the ill-effects of the press reports may have had a lasting impact upon the efficacy of the VD treatment campaign across the country, and that while the true facts of the *Garner v Garner* case were in favour of the Ministry's stance, another case could easily arise in which the circumstances posed a more genuine threat to the confidentiality of patient information. Thus, by clearing up the

¹⁵ PRO MH78/253 Morant to Cox 21 February 1920.

¹⁶ PRO MH78/253 Cox to Morant 26 February 1920.

present misapprehension of the regulations for doctors, by way of inserting a letter in the medical press alone, greater clarity could be maintained for the future.

An edited version of the draft letter, signed by Newman, and dated 31 March 1920, was subsequently circulated to medical officers of VD treatment centres and medical officers of health counties and county boroughs. A copy of the letter was also included in Newman's first annual report as Chief Medical Officer.¹⁷ The report contained a section devoted to the question of professional privilege in relation to the work of VD clinics, in which it was again stressed that while there was an obligation of secrecy this could not override the law. Echoing Gwyer's earlier optimism the section concluded: 'If called upon to give evidence which violates the rule of professional confidence the doctor may properly appeal to the court for protection and to such an appeal the Court would, no doubt, so far as the law permits, give full and sympathetic consideration.'¹⁸

Three weeks after Newman's circular, the Ministry received another letter requesting advice on what course should be adopted when a medical officer was subpoenaed and compelled to give evidence in court. The sender, Hugh Woods of the London & Counties Medical Protection Society, requested that the Ministry receive a deputation of members to discuss the matter and its clear importance to the overall success of the VD treatment campaign. Gwyer advised that a deputation should be received as the question's growing importance indicated that it might be worthwhile to 'guide' medical opinion into 'moderate and reasonable channels from the outset.'¹⁹

Accordingly, on 6 May, Addison, accompanied by Sir Arthur Robinson, Newman and Gwyer, received the deputation from the London & Counties Medical Protection Society. Robinson had joined the Ministry following the death of Morant the previous month. The deputation stressed their belief that a privilege, akin to that of the legal profession, was now required for medical practitioners. They made clear that any such privilege should only be applicable to evidence in civil cases and would not impact upon their standing in criminal proceedings. Addison expressed his agreement with their views suggesting that in order to achieve their mutual goal, legislation would be required. He assured them that he would give the matter his consideration, and the meeting's minutes record that, after the deputation had left, he instructed

¹⁷ *Annual Report of the Chief Medical Officer 1919-1920* (London: His Majesty's Stationery Office, 1920), 163.

¹⁸ *Ibid.*

¹⁹ PRO MH78/253 Gwyer to Newman 26 April 1920

Gwyer to draw up a note on which he could see the Lord Chief Justice (Rufus Isaacs, Lord Reading).²⁰

Gwyer drew up a memorandum and it was sent along with a copy of the VD regulations and Newman's circular, to Sir Claud Schuster, Permanent Secretary to the Lord Chancellor, on 3 June. The accompanying letter asked for the memo to be passed on to the Lord Chancellor (F E Smith, Lord Birkenhead), and requested that he advise Addison on what action should be taken to secure a form of privilege for medical practitioners in court which would ensure the confidentiality of VD patients. Gwyer put forward a number of arguments for the extension of privilege to medical practitioners in civil proceedings, citing the importance of confidentiality to the VD treatment scheme and the lenient treatment received on numerous occasions by members of the clergy appearing as witnesses in court. He argued that the basis for legal privilege as stated by Knight Bruce in *Pearse v Pearse* provided just as much justification for medical privilege:

Truth, like all other good things, may be loved unwisely, may be pursued too keenly, may cost too much. And surely the meanness and the mischief of prying into man's confidential consultations with his legal adviser, the general evil of infusing reserve and dissimulation, uneasiness, suspicion, and fear, into these communications which must take place, and which, unless in a condition of perfect security, must take place uselessly or worse, are too great a price to pay for truth itself.²¹

There followed some brief correspondence between Schuster and the Ministry regarding further copies of the memo being sent, at Birkenhead's request, to the Lord Chief Justice (Lord Reading), the Master of the Rolls (Lord Sterndale) and the President of the Probate, Divorce and Admiralty Division (Sir Henry Duke), for their consideration and comment, and to ask Reading to raise the matter at a judges meeting.²²

²⁰ PRO MH78/253 Minutes of meeting with deputation from London & Counties Medical Protection Society 6 May 1920.

²¹ *Pearse v Pearse* 1 De Gex & Sm, 28 29 as quoted in PRO MH78/ 253 Addison to Birkenhead 3 June 1920

²² PRO MH78/253 Schuster to Barter 9 June 1920; Barter to Schuster 11 June 1920.

Having initially written to the Lord Chancellor at the beginning of June 1920, Birkenhead's failure to furnish the Ministry with the requested opinions prompted Barter to write again in early December.²³ Still there was no response. It took a letter from the ever dependable Gwyer in late January to obtain a long overdue and highly unsatisfactory response.²⁴ Writing the following day, Schuster indicated that he had, as yet, only received a written reply on the question of medical confidentiality from Sir Henry Duke. In addition to this, he had had several discussions of the matter with Lord Reading. Neither had been particularly favourable to the proposal and the matter had been postponed until a meeting of the chief judges could be arranged to discuss it. Additional delays were foreseen in relation to the imminent change of Lord Chief Justice as Reading was vacating the post in order to become Viceroy of India.

This reply, while breaking the silence from legal quarters on the subject, proved unsatisfactory to the Ministry. They were keen to proceed in promoting the cause of medical privilege amidst mounting controversy and pressure. In a written response to Birkenhead, emphasis was again put on the prejudicial effect that the perceived lack of confidentiality was having on public health measures.²⁵ Adverse reports in *The Times* of the Ministry's medical record card system seemed to have failed, once again, to take note of the facts. The system of record cards, introduced as an integral part of the National Insurance scheme, had been put on hold in 1917 due to 'the great pressure upon the time of practitioners, occasioned by the withdrawal of so many of their number for military service.'²⁶ Before recommencing with the system, Addison had engaged an interdepartmental committee to advise on ways in which the forms used for the reports could be improved.²⁷ The new record card system was implemented along the exact lines of the recommendations contained in that interdepartmental committee report, including one that received a lot of negative press attention.

A practitioner is required to afford to the Medical Officer...or to such other person as he may appoint for the purpose, access at all reasonable times to any records kept by the practitioner under these terms of service and to furnish the

²³ PRO MH78/253 Barter to Schuster 3 December 1920.

²⁴ PRO MH78/253 Gwyer to Schuster 25 January 1921.

²⁵ PRO MH78/253 Addison to Birkenhead 4 February 1921.

²⁶ *Interdepartmental Committee on Insurance Medical Records* (London: His Majesty's Stationery Office, 1920), 5.

²⁷ *The Times* 13 March 1920.

Medical Officer with any such records or with any necessary information with regard to any entry therein as he may require.²⁸

The scheme was designed to allow the Ministry of Health to collect more accurate statistics on the health of insured patients. The medical records of a patient would be put inside an envelope with their details on the outside for identification purposes. In the event of the records having to be sent to a Medical Officer, the patient's file would be placed within a windowed envelope for transit – a point of grave concern for *The Times*: 'thus a messenger who handles these cards may find it difficult not to see whom they concern. The whole thing is public and open to the last degree.'²⁹ In an attempt to awaken the public to the threat that the new scheme posed to the confidentiality of insured persons' health records, *The Times* published a series of articles related to this 'medical inquisition.'³⁰ Amidst genuine points that the scheme discriminated against the confidentiality of panel patients and fine rhetoric about confidentiality being 'the breath of medical practice'³¹, *The Times* strayed into scaremongering. Referring to the fact that a Medical Officer could appoint someone to act on his behalf *The Times* suggested 'there is absolutely nothing in the regulation so far as can be seen to prevent one of the new advisers nominating, say, his wife to scrutinise these most private and confidential documents.'³²

Addison's letter to Birkenhead pointed out that the newspaper campaigns, 'inspired by motives which have very little connection with a desire to promote the efficiency of our medical services,'³³ were creating a deal of uneasiness amongst the more 'ignorant' of insured individuals and were an encouragement to those doctors 'who never lose an opportunity of vilifying the panel system.'³⁴ All this was simply adding to the importance of the question of medical confidentiality and Addison concluded by stating:

²⁸ *The Times* 26 November 1920.

²⁹ *Ibid.*

³⁰ *The Times* 26 November 1920; 24 December 1920; 26 December 1920; 30 December 1920; 31 December 1920; 1 January 1920; 3 January 1920.

³¹ *The Times* 18 February 1920.

³² *The Times* 26 November 1920.

³³ PRO MH78/253 Addison to Birkenhead 4 February 1921.

³⁴ *Ibid.*

I entertain no doubt that if the Cabinet should agree to the introduction of legislation amending the present law public opinion would be wholly with us, but in a matter so nearly affecting the practice and procedure of the Courts, I should be glad to know that I am assured of your support.³⁵

The Ministry's anxiety that the question should be dealt with as early as possible did nothing to change Birkenhead's measured approach. Replying on his behalf, Schuster restated that circumstances, primarily the change of Lord Chief Justice, could not permit the reporting of a consensus of legal opinion on the matter.³⁶ It would, after all, be highly improper to proceed without consulting the principal judicial officers who would be most materially affected by any change in the law. In fact, Birkenhead was debating with the Prime Minister, Lloyd George, about who should be appointed Lord Chief Justice. On the day that Schuster wrote to Addison on behalf of the Lord Chancellor, Birkenhead was himself preparing a 'lengthy typewritten document' to try and dissuade Lloyd George from appointing A.T. Lawrence to the vacant position.³⁷ His protestations failed and, in order to keep his Liberal ally Sir Gordon Hewart (the Attorney-General) in the Cabinet, Lloyd George appointed the 77 year-old Lawrence to the position on the understanding that he would be replaced by Hewart before the next change in government.³⁸

Schuster's response had clearly stretched Addison's patience. He wrote to Birkenhead on Valentine's Day 1921 expressing his keen disappointment and emphasising, once again, the pressing nature of the matter, which was, he stated, certain to be raised in Parliament very soon. But any attempt to pressurise the Lord Chancellor into support of the Ministry's proposed alterations to existing legislation was dealt a severe blow by Birkenhead's response:

Dear Minister of Health,

You must allow me to point out that it is perfectly futile of you to write me such letter on grave legal matters as that which I received from you this morning. The changes which you desire are far-reaching and highly disputable. I am myself at

³⁵ Ibid.

³⁶ PRO MH78/253 Birkenhead to Addison 9 February 1921.

³⁷ P Rowland, *Lloyd George* (London, 1975), 533.

³⁸ The Second Earl of Birkenhead, *The life of F.E.Smith. First Earl of Birkenhead*, (London, 1959), 402-7.

present opposed to them. The President of the Probate, Divorce and Admiralty Division is very strongly opposed to them. The delay, therefore, to which you make such querulous reference, until the Lord Chief Justice is appointed and possibly the new Attorney General, is entirely in your favour, as it may conceivably, however improbably, supply you with two Judges who agree with your views.

Nothing in the meantime is to be gained by concealing you from my own view –

- 1) that it is highly doubtful whether you will ever obtain the modification of the existing law which you desire, and
- 2) that it is even more doubtful whether such a modification, if admitted, would not be extremely pernicious.

In conclusion, I have only to add that there will be no avoidable delay in consulting the new official, or officials and that you will be immediately informed of the result.

Yours very truly,

Birkenhead.³⁹

Unperturbed by what Gwyer termed the ‘very strange’ reply from the Lord Chancellor, Addison subsequently met with Birkenhead who undertook to raise the matter within two weeks of the appointment of the new Lord Chief Justice, discuss it with the other judges, and report back to the Minister. Gwyer, ever the optimist, suggested that Addison should not read too much into Birkenhead’s unfavourable stance on the Minister’s proposal since ‘the letter scarcely represented his considered judgement, and indeed bore the appearance of having been written in a moment of pique.’⁴⁰ Obviously, the Ministry had not given up hope of convincing the judiciary of the benefits of medical privilege. One month later, a communication from Schuster indicated an imminent meeting between Birkenhead and Lawrence. In light of the circumstances of the elderly Lawrence’s appointment, there was, perhaps, not much ground for hope. Shortly afterwards, Schuster confirmed that Lawrence was in full agreement with the informally expressed views of his predecessor, of Sir Henry Duke (President of the Probate, Divorce and Admiralty Division) and of Birkenhead.

³⁹ PRO LCO 2/624 Birkenhead’s reply to Addison’s letter of 14 February 1921.

⁴⁰ PRO MH78/253 Gwyer to Machlachlan 5 April 1921.

Clearly, this did represent the considered judgement of the judiciary and its foundation could not be as easily belittled as Birkenhead's previous response. To Birkenhead, the unanimous legal opinion meant Addison's proposal could be taken no further.

The attempt to state that the question was closed seems to have spurred the Ministry - not content to have what they could and could not achieve dictated to them by the judiciary - into greater action. Besides, not all avenues had been exhausted. In a note on the back of the letter, Sir Arthur Robinson suggested that the only way to take the matter forward would be by referring the question formally to the Cabinet as a matter of difference between the Ministry and Lord Chancellor's Office. He requested that, before suggesting this to Addison, information on medical privilege in other countries should be obtained.

In late May, Gwyer set out his reasons for believing the matter should be pursued.⁴¹ He argued that the question of medical privilege was ultimately one of policy and, consequently, legal opinion, while carrying great weight, could not be regarded as conclusive. Furthermore, the Lord Chancellor's Office had not given detailed reasons for their decision. Gwyer suggested that the Society for Comparative Legislation should be consulted in order to furnish the Minister with the information on the standing of medical privilege in other countries, before any approach was made to the Cabinet. On the question of raising the matter with Cabinet, he noted a positive precedent occurred when proposals to make housing bonds a trustee security under the Housing (Additional Powers) Act, 1919, were met with unanimous opposition from the judges of the chancery division. In that instance, the Cabinet did not accept the judges' opinion as final and the proposal went on to become a statute. Newman agreed with Gwyer's view that the question should not be left, believing there were 'strong medical grounds for the course proposed.'⁴²

The Society for Comparative Legislation was contacted and Mr Bedwell from the Society replied to the Ministry on 13 June 1921. He opined that the dominant influence of Roman Catholicism in the European countries made them ill-suited for current purposes but he believed that the United States might prove more fruitful. He was not aware of a collected work that contained information on the policy adopted in other countries, but he suggested that it would not take long for someone from the

⁴¹ PRO MH78/253 Gwyer to Newman and Robinson 31 May 1921.

⁴² PRO MH78/253 Newman handwritten comment on Gwyer's memo 3 June 1921.

Ministry to research the matter in the Middle Temple library, where he himself was the librarian. Bedwell's advice seems to have been taken as the Ministry's file contains several pages of notes on legislation regarding medical confidentiality in countries ranging from New Zealand and Canada to many of the American states. Gwyer used this information in a memo he drew up for the Cabinet.⁴³ In relaying it to Robinson, Gwyer noted that he had been in touch with Mr Miller-Gray of the Scottish Office who had informed him that while there was no privilege for medical men in Scotland, it was felt that 'Doctors should not be pressed to give evidence about their patients unless absolutely necessary.'⁴⁴

While the Ministry sought out ways to develop their case at the highest levels of government, the growing problems for Lloyd George's coalition saw the Prime Minister take Addison away from Health to become Minister without portfolio. Having waited for the appointment of the new Lord Chief Justice only to see the position filled by the elderly Lawrence, whose primary function was to keep the seat warm for Hewart (who succeeded him twelve months later), the Ministry was by April adjusting to a new Minister of Health. Lloyd George's removal of Addison, ostensibly because of the difficulties connected with the cost to the public purse of his ambitious housing program, came at a bad time for the Ministry. The founder of Imperial Chemical Industries, Sir Alfred Mond, took over as Minister when the department was gearing-up to persuade cabinet of the case for medical privilege. A delay in making the approach to cabinet was out of the question as the issue gathered an increased urgency after it became apparent, towards the end of July, that Lord Dawson of Penn was to raise the matter for debate in the House of Lords and suggest that a select committee of the two Houses of Parliament should analyse the question. Dawson had chaired the 31st meeting of the Consultative Committee on Medical and Allied Services at the beginning of July, in which the question of medical privilege had been prominent amongst a number of issues the Ministry had requested the committee to examine and report back. The minutes of the meeting express at some length the discussion that took place, including the appearance and advice of Gwyer midway through the meeting. Going against Gwyer's advice, the committee finally passed the following resolution: 'In the opinion of the Council it is in the public interest that medical practitioners should not be compelled in proceedings in courts of

⁴³ PRO MH78/253 Ministry memorandum for Cabinet meeting June 1921.

⁴⁴ PRO MH78/253 Gwyer to Robinson 17 June 1921.

law to disclose communications made to them by their patients'⁴⁵ by majority of 11 votes to 3. The three dissenters on the committee agreed with Gwyer's opinion that the protection afforded to medical men should be limited to civil cases.

Dawson's belief that medical privilege should extend to both civil and criminal proceedings went against the Ministry's view of the issue and the prospect of his raising the issue in Parliament threatened to jeopardise their proposal relating solely to civil cases. Mond wrote to Birkenhead later the same month.⁴⁶ He noted the correspondence that the Lord Chancellor had entered into with Addison and indicated that he had been keen to arrange a meeting to discuss the matter. Mond made clear that, while Dawson's proposal was not in keeping with the Ministry's views on the question, the perceived absence of a complete guarantee of secrecy under the government's VD treatment schemes had led to something approaching a crisis. In contrast to Dawson, the Ministry sought to gain legislation that would permit a level of privilege to medical practitioners in civil cases alone, for which there were a number of respectable precedents. Indeed, Mond suggested, a short bill could be passed along the lines of legislation in force in New Zealand, which stated

A physician or surgeon shall not, without the consent of his patient, divulge in any civil proceeding (unless the sanity of the patient is the matter in dispute) any communication made to him in his professional character by such patient, and necessary to enable him to prescribe or act for such patient.

Nothing in this section shall protect any communication made for any criminal purpose, or prejudice the right to give in evidence any statement or representation at any time made to or by a physician or surgeon in or about the effecting by any person of an insurance on the life of himself or any other person.⁴⁷

If Birkenhead concurred, there would be no need for a joint committee to discuss the matter and the Ministry could explain the situation to Dawson. If Birkenhead was of another mind, then Mond was keen to discuss the situation with him. Clearly Mond was trying to use Dawson's extreme position with talk of select committee

⁴⁵ PRO MH78/253 Consultative Council on Medical and allied Services 1 July 1921.

⁴⁶ PRO MH78/253 Mond to Birkenhead 21 July 1921.

⁴⁷ Extract (sections 2 and 3) from the Evidence Act, 1908 (New Zealand).

investigations and a universal medical privilege to contrast the Ministry's more moderate and reasonable position.

In the end, the Ministry persuaded Dawson to withdraw temporarily his motion.⁴⁸ Robinson claimed Dawson had been 'made to see the difficulties' at various discussions at the Ministry.⁴⁹ Nonetheless, the Ministry still faced mounting pressure to clarify the position of medical confidentiality in connection with VD treatment. Two letters on the subject were received in the autumn of 1921, the first from the Monmouthshire County Council Association and the second from the County Councils Association. Both referred to the inconsistency between the Ministry's advertisement posters for VD treatment centres, which clearly stated that all proceedings would be strictly confidential, and the recent string of highly publicised legal rulings which falsified that claim.⁵⁰ Either, the letters demanded, the Ministry must have secrecy recognised by the courts, or the literature would have to be withdrawn. The second letter had been forwarded on from the Ministry of Health in Cardiff, who, believing the issues raised to be of widespread concern, suggested that a reply would be better to come from Whitehall.⁵¹ The Ministry at Whitehall's reply simply stated that they had the matter under consideration.⁵²

The delay in tabling his motion for discussion did not deter Dawson from continuing his campaign for medical privilege. Consecutive issues of the *Law Times* on 25 March and 1 April 1922 covered at length a debate on professional secrecy opened by Dawson at the Medico-Legal Society. The report of the debate can be extended to sum up quite effectively the central tension involved in the discussion of medical confidentiality. On the one hand, the Ministry and the BMA were arguing that medical privilege, of a form and size that could be debated, was necessary for practitioners to carry out their professional duty and promote the health of the public. On the other hand, the Judiciary emphasised the doctor's duty as a citizen to aid in the administration of justice. Both sides claimed the justification that their course of action best served the public interest. The case became, therefore: doctor's duty as citizen versus doctor's duty as professional. If the complexities involved in weighing up the two duties against each other could not provide a satisfactory resolution, no

⁴⁸ *The Times* 28 July 1921.

⁴⁹ PRO MH55/184 Robinson 23 July 1927.

⁵⁰ PRO MH78/253 Hughes to Ministry 19 July 1921; Johnson to Ministry 5 November 1921.

⁵¹ PRO MH78/253 Ministry of Health Cardiff to Slator 9 November 1921.

⁵² PRO MH78/253 Slator to Johnson

simpler solution would be found by focussing on the consequences. After all, who could definitively state that the end of public justice was more important than that of public health, or vice versa? Nonetheless, despite differing standpoints, all those attending the Medico-Legal Society's debate were agreed that answers to this complex question were urgently required. Lord Justice Atkin suggested that the topic was 'on the whole the most important that had ever engaged the attention of the society, because it was one that intimately concerned not merely medical men, and not merely lawyers in their capacity as ministers of justice, but the public at large.' Medical confidentiality was to continue to engage Atkin's attention as he lent the weight of his support behind attempts to gain medical privilege through private members' legislation in 1927 and 1936.

Dr Elliot: The Ministry's Medical Martyr

Andrew Morrice bemoans the absence of a dramatic courtroom showdown in the early interwar debate.⁵³ In fact, such a showdown was on the verge of taking place in 1921. In early June 1921, Dr John Elliot, medical officer to a VD clinic in Chester, wrote to the Ministry, in urgent need of advice.⁵⁴ He had been subpoenaed to appear as a witness in the divorce court and give evidence against a patient, thereby breaching medical confidence. The patient had attended the VD clinic with her child who suffered from the gonorrhoeal eye infection *ophthalmia neonatorum*. Her husband, claiming to be disease free himself, took the presence of disease in the child as evidence that his wife had contracted the disease during an adulterous relationship. Consequently he petitioned for divorce and subpoenaed Dr Elliot to give evidence on the presence of the disease. In writing to the Ministry, Elliot was keen to know if he had no other choice but to give evidence in the pending trial. Replying the following day, Coutts explained the position as the Ministry currently understood it. 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 should remain confidential. If the appeal for exemption was not granted, Elliot was left with only two options: have the protest recorded and then answer the questions, or, refuse to give evidence. If the latter course was adopted, the witness ran the risk of

⁵³ A Morrice, 'Should the Doctor Tell? Medical Secrecy in Early Twentieth Century Britain', 75.

⁵⁴ PRO MH78/253 Elliot to Coutts 3 June 1921.

imprisonment for contempt of court, which, while being of personal discomfort, would 'no doubt very effectively draw attention to the hardship of the position.'⁵⁵ Perhaps, Coutts continued, Elliot could furnish the Ministry with details of when the trial was to take place in order that they could send a shorthand writer to take notes on the court's actions, and Elliot himself could drop by the Ministry to discuss the best way to put any protest he wished to make. Coutts also suggested that Elliot might wish to get in touch with legal counsel, though it was unlikely he would be permitted to use them in court.

Elliot's next letter stated that the importance of the case was such that he felt he might not have the confidence to put the protest effectively so he had corresponded with Honaratus Lloyd K.C.⁵⁶ Clearly passionate about the issue, Elliot claimed to be of a mind to decline to answer any questions and face the consequences, though he reserved any final judgement until he had talked the matter over with Lloyd. The case was *Needham v Needham* and while he felt sure he would have the support of the whole profession, he hoped he would also have the support of the Ministry, as far as it was possible for them to give it. The latter, it turned out, was an important qualification.

On receiving this letter, Coutts sent a note to Gwyer indicating that, although Elliot had engaged the services of a lawyer, it appeared he might be a willing - and timely - martyr in the Ministry's cause of medical privilege.⁵⁷ Coutts suggested

I think it is very probable that if we gave him direct encouragement he would decide to decline to give evidence and thus make it a test case. I recognise however, that we could not well do this officially, and it is a great responsibility to advise him unofficially in this direction.⁵⁸

A great responsibility, indeed, but also a great opportunity. Having received a negative response from Birkenhead on their proposal to extend a form of legal privilege to doctors, the senior members of the Ministry were keen to continue their promotion of what they believed was a justified and necessary cause. The coincidental arrival of Elliot's plea for help knocked the door, so firmly closed by the consulted

⁵⁵ PRO MH78/253 Coutts to Elliot 4 June 1921.

⁵⁶ PRO MH78/253 Elliot to Coutts 5 June 1921.

⁵⁷ PRO MH78/253 Coutts to Gwyer 6 June 1921.

⁵⁸ Ibid.

legal opinion, once again ajar. The circumstances seemed ideal. In the course of researching the matter over the previous months, the Ministry had frequently come across references to the informally recognised privilege granted to clergymen when appearing as witnesses in court. Memoranda in the Ministry's file noted precedents in which the judge ruled against the disclosure of confidential information by a clergyman.⁵⁹ The assumption was that judges were reluctant to 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 their sense of higher duty. The Ministry now seemed keen to test whether the same leniency would be shown to a doctor who, in face of dire consequences, resolutely stood by his belief in the ancient and venerable principle of medical confidentiality. Elliot could provide them with their test case, but first he had to be persuaded of the contribution his potential, even likely, sacrifice would make to the greater good of the cause. Yet the matter was more delicate. The guiding hand of the Ministry must leave no obvious fingerprints on the wary Dr Elliot's back as it pushed him through the door and into the spotlight of public attention, or, prison.

However, the Ministry were not the only ones advising Elliot. Lloyd's counsel to him, as stated in Elliot's next communication with the Ministry, was that, while initially refusing to give evidence, if the court maintained its demand, Elliot should comply.⁶⁰ In addition to appearing as a witness, Elliot was required to bring the hospital records with him and the secretary to the infirmary was also likely to be subpoenaed. Writing on a Tuesday, Elliot was to meet with the Infirmary's chairman, secretary and solicitor on the following day before travelling to London on Thursday to meet with the London & Counties Medical Protection Society, from whom he had requested counsel. He understood the trial could be called on Friday. With so many demands upon him it is little wonder Elliot concluded by stating 'I don't quite know what to do.'⁶¹ The only other communication the Ministry received from Elliot, before his appearance in court was a telegram from Chester simply stating 'Trial Tomorrow Coming to town will call Ministry Seven Ock.'⁶²

The *Daily Chronicle*, which ran two stories relating to the *Needham v Needham* trial on 10 June 1921, and a follow-up article gauging the medical

⁵⁹ Best in *Broad v Pitt*, 3 C & P 519; Alderson in *R v Griffin*, 6 Cox 219.

⁶⁰ PRO MH78/253 Elliot to Ministry.

⁶¹ Ibid.

⁶² PRO MH78/253 Post office telegraphs telegram from Chester to Ministry.

profession's reaction on the 11th eagerly recounted Elliot's performance in court. The reports noted his prolonged attempt to have medical privilege recognised by the court, 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, Justice Horridge, flatly stated that such regulations held no jurisdiction in the King's courts. Despite further protests that the privilege 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, Horridge ordered Elliot to assist in the administration of justice and answer all questions. Elliot acquiesced. In sweeping style the *Daily Chronicle* announced to its readers

It is clear that if there is no guarantee of professional secrecy in certain kinds of clinic the whole object of the Ministry of Health acting in the interests of the public is likely to be defeated. The matter requires legislation.⁶³

As had been the case in the aftermath of the *Garner v Garner* trial, it was the legal journals that seemed to take the dimmest view of the judge's ruling. In the *Law Journal* of 18 June 1921, criticism was made of Horridge's demand for the medical witness to provide a statutory basis for medical privilege. No such statutory proof could be had for the privilege enjoyed by the lawyer or the minister of religion, though both were customarily recognised. The grounds for both were the interests of public policy in carrying out the administration of justice. But, public policy clearly emphasised the need for unfettered communications between patient and doctor under the advertised pledge of secrecy for the VD treatment scheme. These adverse legal decisions could deter individuals from seeking treatment under the government's scheme and, clearly, this was not in the public interest. The article concluded: 'A strong judge is required to create a precedent that would be beneficial to the public as well as fair to medical men.'⁶⁴

This point was not lost on the Ministry. A memo from Coutts to Newman indicated that he, along with Gwyer, had met with Elliot on 9 June to discuss the line of argument that should be taken. They had decided that counsel from the London & Counties Medical Protection Society should be used, if possible, to put forward

⁶³ *Daily Chronicle* 10 June 1921.

⁶⁴ *Law Journal* 18 June 1921.

Elliot's case. This request had not been granted by Horridge, though Coutts clearly believed that Elliot had presented their case well. In acceding eventually to give evidence, after entering his protest, Elliot acknowledged 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. The Ministry's problems were clearly mounting. Elliot, their spokesman in the case, had failed to convince the judge of the need for medical privilege. Moreover, he had flinched in court at the prospect of a prolonged imprisonment. But losing their medical martyr was only the beginning of the Ministry's predicament. The detrimental impact that the ruling, and particularly the press reports of it, could have on VD sufferers seeking treatment from the Government's scheme of confidential clinics were exacerbated by the possibility that VD medical officers were themselves disillusioned with the system. Coutts noted that Elliot was seriously contemplating giving up his position at the VD clinic, and another letter received from Dr Gibson, a VD medical officer in Oxford, made clear the strong feeling that 'this ruling of Mr Justice Horridge puts us in an altogether false position with our patients.'⁶⁵

The prospect of losing medical officers from VD clinics, on top of everything else, was potentially catastrophic for the Ministry. Coutts proposed that the issue should be pressed, that strong leading articles on the subject should appear in the medical journals, and that the Ministry should meet for discussions with the Royal College of Physicians, Royal College of Surgeons and the BMA.⁶⁶ He suggested some of the daily newspapers might also be willing to take the matter up. Concurring with Coutts' assessment of the seriousness of the situation, Newman forwarded the memo on to Gwyer with a note stating: 'You will wish to see this in view of your memo for the minister. I think we ought to try and act at once. It is important we should not lose our VD officers.'⁶⁷

On 20 June, Hugh Woods, secretary to the London & Counties Medical Protection Society wrote to the Ministry, inviting them to meet the costs which the Society had incurred in their support for Elliot.⁶⁸ He insisted that the Ministry must act in order to ensure that medical officers who took up their posts believing that confidentiality would be observed would see the regulation protected and enforced. It

⁶⁵ PRO MH78/253 Gibson to Coutts 10 June 1921.

⁶⁶ PRO MH78/253 Coutts to Newman 13 June 1921.

⁶⁷ PRO MH78/253 Newman to Gwyer 13 June 1921.

⁶⁸ These amounted to £32 15s.

could not be expected that busy practitioners would risk prolonged imprisonment for carrying out what they believed was their recognised duty. If the legislature failed to deliver such protection then '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.'⁶⁹ The onus was on the Ministry to provide the circumstances in which the medical officers could maintain their duty of secrecy, which the Ministry's regulations rightly imposed upon them. A further letter on the 5 July indicated that Dr Hallam from the syphilis and skin clinic at the Royal Infirmary, Sheffield, had been subpoenaed to produce all records, notes and memoranda relating to a patient from his clinic. Hallam was responsible to the Ministry for these records and so their advice was being sought on whether he should produce them. Woods ended on an ominous note, stating that the very existence of these types of clinics was involved in the question. The Ministry sent a negative reply with regard to the request for expenses. They claimed they had no funds for this purpose, and it had been made clear to Elliot in the meeting before the case that while the Ministry sympathised with his position they could offer him no financial assistance. As for Hallam, if he had been subpoenaed he must attend.⁷⁰

In fact, Hallam was exempted from attending in court. In a series of letters in early June, Hallam and his colleague, Dr Mouat, both of whom had been subpoenaed to appear in the case of *Atwood v Atwood* in the divorce court, requested advice from the Ministry to whom, they felt, they were responsible for the medical records of patients.⁷¹ The information required by the court related to a patient who had been treated for gonorrhoea at the VD clinic in Sheffield. Mouat was in charge of the treatment of this particular disease while Hallam specialised in treatment of cases of syphilis. Consequently Hallam had not been in contact with the patient concerned. The Ministry advised Hallam to write to the solicitor in charge of the case and explain these circumstances to him, and in a brief note to the Ministry from the London & Counties Medical Protection Society, it was declared that Hallam's subpoena had been withdrawn. Mouat, however, could only be given the, somewhat worn and hollow, advice that he must attend as a witness under subpoena but could attempt to claim that the information requested was privileged. If the judge refused, he must give

⁶⁹ PRO MH78/253 Woods to Ministry 20 June 1921.

⁷⁰ PRO MH78/253 Slator to Woods July 1921.

⁷¹ PRO MH78/253. Mouat to Newman 2 July 1921; Ministry to Mouat 4 July 1921; Hallam to Newman 4 July 1921; Coutts to Hallam 5 July 1921.

evidence unless he was willing to risk imprisonment for contempt of court. It was a sign of how little progress had been made on the issue by the Ministry that they included a copy of Newman's letter circulated to medical officers at VD clinics, which had been written in February 1920.

Alfred Cox wrote to the Ministry on the 23 June to say that, in light of Horridge's ruling in *Needham v Needham*, the BMA council had passed the following resolution:

That the Council of the British Medical Association has learnt with great concern of the position created by the recent decision of a Judge that the medical officer of a venereal disease clinic must give evidence in a civil case as to the medical condition of a patient under his care at a venereal disease clinic, thus violating the confidence between doctor and patient and the direct undertaking given by the Local Government Board that all proceedings at such clinics should be absolutely secret and confidential. In drawing the attention of the Ministry of Health to these facts the Council of the Association would urge that such legislative steps should be taken as would render such an occurrence impossible in the future.

The Association further requested that Mond receive a deputation from the BMA council to discuss the matter in the hope of inducing him to take steps towards securing the required legislation. The proposed meeting did not take place, due to the proximity of the BMA annual general meeting. However, the Association was able to report that another resolution of relevance had been adopted amidst overwhelming support:

Resolved: That the Association use all its power to support a Member of the British Medical Association who refuses to divulge, without the patient's consent, information obtained in the exercise of his professional duties, except where it is already provided by Act of Parliament that he must do so.

John Elliot may not have provided the Ministry with the martyr they secretly wanted but he did bring the question of medical privilege in civil proceedings back into the spotlight, sparking debates in the popular press, medical and legal journals. The

recurring references to him and the *Needham v Needham* case ensured that his prolonged protest had secured publicity for the cause. In an article titled ‘Should doctors tell?’ in the *Daily Chronicle* of 19 November 1921, Elliot received a number of tributes for his role in bringing the matter to greater public attention. The Ministry, while still suffering in the aftermath of failing to gain ground towards securing medical privilege, could be pleased by Elliot’s performance. Furthermore, they need not give up all hope of a martyr. In the same article that praised the efforts of Elliot, Dr H W Baley of Harley Street was quoted as stating:

I regard the confidence between patient and doctor of so much importance that if I were put into the witness box I would go to prison rather than give away my patient. A doctor should not be obliged by the law to give away his patient except in cases of crime.

It is probable that, just like Hawkins in the Duchess of Kingston’s trial 150 years before, Baley was utilising the press attention to advertise his high ethical beliefs – and thereby attract paying patients. He adopted the same tactics in the aftermath of a similar case in 1927.⁷² Nonetheless, with both the BMA and the London & Counties Medical Protection Society starting to echo their thoughts on the merits of martyrdom, the possibility of a *Harley-Street* martyr must have been a pleasing prospect for the Ministry.

⁷² For a detailed account of this see chapter 7.

Chapter 5 – The British Medical Association

Introduction

While no single organisation could claim to represent the opinions of the whole of the medical profession, there are a number of reasons for examining the BMA's position on medical confidentiality. Although the Royal College of Physicians and the Royal College of Surgeons were both involved in the question, it was the BMA which was at the forefront, both in 1915 and in the early interwar years – sending delegations to meet with the Ministry of Health and the law officers of the Crown. This was, in part, because the issues which were raising difficulty, in particular the government sponsored VD treatment scheme, were more likely to affect general practitioners and medical officers engaged at public treatment centres than high-ranking private practitioners. While the specific issues would more readily engage the attention of the BMA membership, there are strong grounds for seeing the BMA as the body which represented general medical interest by the interwar years.

The BMA gained much valuable experience in the debate over the implementation of the national insurance measures before the war. This experience of negotiating with government and attempting to represent the medical profession at large was an important learning curve. As Peter Bartrip points out:

Even if the BMA is deemed to have lost the national insurance contest in terms of not achieving everything it desired and of having to make a humiliating climbdown, it won in terms of acquiring recognition as the voice of the profession. It thereby ensured that no future government would be able to ignore it....It had won a place at the top table for all future negotiations relating to the health of the nation.¹

Recognised as a key medical body with which government would negotiate, the BMA's major contribution in organising the medical profession in support of the war effort further improved its status by the early interwar years: 'it emerged from the war with a much enhanced reputation both in the eyes of the authorities and of the profession at large.'² Thus, heavily involved in the debate over confidentiality both

¹ P Bartrip, *Themselves Writ Large. The British Medical Association 1832-1966* (London, 1996), 163.

² *Ibid.*, 181.

before and into the interwar years, the BMA was well placed to provide an important medical perspective.

However, the BMA was not a homogenous mass with a single opinion. Consultants and GPs, both of whom were represented in the organisation, often appeared to be at loggerheads, a point highlighted by the rise of medical guilds around the turn of the twentieth century.³ Moreover, as the BMA of the early twentieth century reformed to become a more democratic organisation – instituting an annual meeting of representatives from around Britain to discuss and vote on policy resolutions – it became clear that the opinions of the membership were not always in agreement with those of its governing council.⁴ Thus, while the BMA appeared relatively unified in its resistance of the legal challenge to confidentiality in 1915, as an organisation it has the potential to provide a range of medical opinions on the debate over medical confidentiality.

In broad terms, the BMA's internal debate was dictated by the calendar with the focal point being the annual representatives' meeting held each spring. At these meetings the representative body of members from around the country would examine policy resolutions brought before them by the BMA council. For the question of confidentiality, the council relied on the central ethical committee (CEC) to clarify the issues and recommend resolutions which the council could approve and deliver to the annual representatives' meeting for ratification by the representative body. At the best of times, the sheer range and complexity of issues that the CEC had to consider and take into account on the question of confidentiality made their task of developing policy resolutions difficult. The intensity of the debate over confidentiality in the early interwar years was to make it more difficult yet.

With cries of “Yes!” and “No!”, The Central Ethical Committee re-evaluates the BMA's position on confidentiality.

1920

Having taken a stand on the question of confidentiality in 1915, the BMA were by 1920 having to think seriously about the practical implications of their position. What support would the Association be willing to give a member who got into difficulty as a result of challenging the courts on medical confidentiality? As noted in the last

³ Ibid., 142.

⁴ Ibid., 158-9.

chapter, the focus of the debate was shifting from abortion to VD. In some respects this strengthened the BMA's position. VD was a disorder for which the medical profession had a monopoly of treatment. By the terms of the Venereal Diseases Act of 1917 all but registered medical practitioners were prohibited from treating VD. It was, thus, easier for the BMA to make a case for confidentiality of treatment based on a professional code of ethics which bound all those legally permitted to carry out such treatment.

In 1920 the BMA council engaged a standing sub-committee of the CEC to examine the question of confidentiality with specific regard to VD. This resulted in a draft memorandum drawn up by the deputy medical secretary, George Anderson.⁵ Opening with a re-iteration of the BMA's previous resolutions on medical confidentiality, it quickly became evident that the siege mentality of 1915 had not diminished:

The main attack on professional secrecy appears likely to come from the bureaucratic side of Government especially from that concerned with the administration of the law.⁶

The law's steady encroachment into the doctor's position of confidence, partly by legislation and partly by judicial decision, defined it as the opposition. Previous attacks, notably by the Lord Chief Justice in 1915, had been successfully resisted but could be renewed at any time. The publicity caused by Justice MacCardie's decision in *Garner v Garner* in January 1920 suggested that resumption would come sooner rather than later. However, allies were at hand in the form of 'certain departments of the Government'⁷ - presumably a reference to the Ministry of Health. Their support would be expected in any stand which the BMA made against further encroachment into medical confidentiality.

Anderson recognised that the doctor's duty of confidentiality was not absolute. Three main exceptions had been insisted upon by the state. Firstly, in a court of law when the court had ruled that information of a confidential nature had to be disclosed. Secondly, under the provision of an Act of parliament such as in notification of

⁵ BMA CEC SSC minutes 9 November 1920.

⁶ BMA CEC minutes 9 November 1920.

⁷ Memorandum from Deputy Medical Secretary BMA CEC minutes 9 November 1920.

infectious diseases. Thirdly, where a doctor's duty as citizen over-rode his professional duty e.g. where he was made aware of information which could prevent a crime, or grave danger to another person, or where disclosure would safeguard the interests of the patient – as in cases of mental disorder.

The first two exceptions were sufficient justification for a doctor to breach confidentiality. However, it was recognised that some practitioners might choose to disobey an order of the court and face the consequences. The CEC felt it would be impossible for the BMA to lay down any general rule as to what action should be taken in such cases. Each would have to be decided upon its own merits. The third exception appeared to pose more problems as there was a greater likelihood of differing opinions about the doctor's duty in individual cases. Again, no general rule could be stated but it was suggested that the doctor should try and persuade the patient to consent to the disclosure. If unsuccessful, the doctor should revert to his conscience and, if time permitted, he could appeal to a judicial committee such as the CEC. The BMA would then have to back any action taken by a practitioner who had exactly followed the advice given by the CEC.

With regard to the question of VD, the annual representatives meeting of 1920 had passed a resolution which bound doctors not to disclose information without patient consent but it was qualified by the first of the exceptions above.⁸ This meant a practitioner was absolved if he disclosed information at the demand of a court. Cause for greater concern were cases in which the onus lay with the practitioner himself to make the decision e.g. in cases of proposed marriage where syphilis was likely to be transmitted from one party to another and to any children which resulted from the marriage.⁹ A common theme in the debate, the case of the syphilitic fiancé was cited by Hempson in a speech to the annual representatives meeting in 1920, by Birkenhead in his published essay 'Should a Doctor Tell?'¹⁰ in 1922, and matches the synopsis plot of the contemporary film 'Should the doctor tell?'¹¹ Anderson suggested that generalisation on the best course of action for the doctor was impossible. The BMA, more than either the Ministry of Health or the Lord Chancellor, had difficulty in

⁸ Minute 74 of the BMA annual representatives meeting, 1920.

⁹ Morrice terms this 'the case of the syphilitic fiancée', a designation maintained here. A Morrice, 'Should the doctor tell? Medical secrecy in early twentieth-century Britain', 68.

¹⁰ F E Smith, 'Should a Doctor Tell?', in *Points of View* (London, 1922).

¹¹ Two versions of the film were made i) a silent movie in 1923 written by GB Samuelson and PJ Ramster ii) a sound and picture version in 1930 written by Samuelson and Edgar Wallace. For more details see the film's entry at: <http://uk.imdb.com>

looking at the problem of the confidentiality issues involved with VD in isolation from the rest of medical practice and Anderson's memo referred to other issues which had raised questions of the boundaries of medical confidentiality in recent meetings of the CEC. But while queries about confidentiality arose in many different contexts, it was clear that VD was becoming the most acute difficulty.

The general advice given by the CEC emphasised the duty of members to maintain the confidences of their patients, and the committee searched for ways to obviate the practitioner from making the ultimate decision to breach secrecy. Doctors were absolved of their duty if their medical evidence was demanded by a judge in court, though they were still advised to begin by attempting to plead privilege. Similarly they were not accountable if medical information was required under statute law. In both situations, the consent of the patient was taken to be implicit on the basis that individuals knew of these exceptions to confidentiality when they consulted the practitioner. Greater complexity arose in areas where a breach of confidentiality was requested or seemed necessary outwith a legal context. The tendency was again to emphasise a passive role for the practitioner in the decision-making process. If information was required by an insurance company, or similar body, the practitioner should always first gain the patient's explicit consent; or if a health certificate was being issued, this could be given to the patient, thereby placing the responsibility firmly away from the practitioner.

Yet, what was the doctor to do if the patient did not take the responsibility of making the decision, or acted in an irresponsible manner? If it was, as the CEC so persistently inferred, impossible to lay down general rules of practice in such situations, then their belief that practitioners should proceed according to their conscience was unlikely to produce uniformity of practice. Practitioners had not all been carved from the same block of wood. Confirmation of this came during Hempson's speech to the annual representative meeting in 1920.¹² Reciting the hypothetical case of the syphilitic fiancé, Hempson asked whether his audience would not ensure that the father of the innocent girl was informed of the health threat from her fiancé. The members of the representative body replied with cries of "No" and "Yes". Clearly doctors were not of one mind and this dichotomous response was later

¹² *BMJ* 24 April 1920.

picked up and used by the judiciary as evidence of the practical difficulties in legislating on medical confidentiality.

Beyond their faith in conscience as a guide, there seemed to be an underlying inconsistency in the CEC's approach. If the practitioner was best placed to be the judge of when to disclose information in cases too complex for fixed guidelines, it is unclear why he should be attempting to minimise his role in other cases. The whole approach inferred a reluctance to take responsibility for disclosure decisions wherever possible, and where it was not possible to defer to another decision-maker, the onus was on individual rather than collective responsibility within the profession.

This was further emphasised by the CEC's decision that the BMA could not be prepared to support its members in maintaining medical confidentiality until a general guiding policy had been laid down. This was a rather empty statement since Anderson's memo, summarising the committee's deliberations on the question, had given a clear indication that no general rules *could* be laid down for members. Driving home the CEC's reluctance to commit BMA resources, Anderson indicated that, even if guiding principles were arrived at, and all members made aware of them, it would still be extremely doubtful whether the BMA could in any way support its members in challenging the law. The facts relative to each particular case would have to be considered before it could even contemplate giving any support. The CEC did endorse some general measures. It was deemed desirable that publicity should be given, in the columns of the *BMJ*, to the CEC resolutions on the subject and that an article should appear annually in order to guide the BMA membership. Thus, having been strong in its vocal defiance of the law's attempts to encroach into medical confidentiality in the years prior to the First World War, when faced with the practicalities of their adopted position, the BMA seemed considerably less sure of itself.

1921

'For they did not wish to be anarchists.'¹³ **Rebellion in the British Medical Association!**

Having hinted in 1920 that a renewal of the legal assault on medical confidentiality was imminent, the BMA council was, by October 1921, having its attention drawn by Hempson to the cases of *Needham v Needham* and *Devonshire v Devonshire and Eve*.

¹³ Reported statement of E B Turner at a special meeting of the BMA Council held to discuss the question of professional secrecy. BMA CEC Minutes 31 March 1922.

The latter case involved a married couple in Ilford who were now estranged. The wife had a still-born child and the husband denied paternity. The medical officer of health for Ilford, Dr Burton, notified the birth including details of paternity according to statute law. Subsequently the husband filed for divorce on grounds of adultery and the judge demanded Burton's information as evidence – overruling protests from both Burton and the Ilford Urban District Council. In both cases medical practitioners had been called upon by judges to divulge patient information in court, but it was the *Needham v Needham* case which formed the basis of a council resolution sent to the Ministry of Health expressing the Association's concerns.

the Council of the BMA has learned with great concern of the position created by the recent decision of a judge that the medical officer of a VD clinic must give evidence in a civil case as to the medical condition of a patient under his care at a VD clinic, thus violating the confidence between doctor and patient and the direct undertaking given by the Local Government Board that all proceedings at such clinics should be absolutely secret and confidential. In drawing the attention of the Ministry of Health to these facts the Council of the Association would urge that such legislative steps should be taken as would render such an occurrence impossible in the future.¹⁴

Accompanying the resolution was a request that Mond receive a deputation from the Association at an early date.¹⁵ In referring to *Needham v Needham*, it was made explicit that doctors were not the only ones under the impression that the treatment of patients within the government VD scheme was to be strictly private and confidential, 'every member of the public'¹⁶ was under the same belief.

While John Elliot's appearance in *Needham v Needham* in early June 1921 had clearly made an impact upon the Ministry and the BMA council, it was the reaction of the membership of the BMA that caused the greatest problems. Coming just a few weeks before the annual representatives' meeting at Newcastle in 1921, Elliot's ordeal became a significant point in the Association's policy development. Following the

¹⁴ BMA CEC minutes 25 October 1921.

¹⁵ It was further resolved that the deputation should consist of the Officers of the Association, together with the Chairmen of the Medico-Political, Insurance Acts, Central Ethical, Hospitals and Scottish Committees. Dr Dain and Dr Garstang were subsequently added to this list.

¹⁶ BMA CEC minutes 25 October 1921. BMA council to Ministry of Health, 23 June 1921.

more moderate recommendations developed by the CEC in 1920, the council put forward a motion with two distinct elements to the representative body at Newcastle. Firstly, members should not *voluntarily* disclose patient information, but if they chose to claim privilege in court, or failed to comply with existing legislation, they could not expect support from the BMA. Secondly, all attempts to add *new* exceptions to the general rule of confidentiality held by the profession, would be resisted by all lawful methods, and the BMA would support, by all means in its power, any practitioner who was penalized through such encroachment. The CEC and council were therefore advocating a staunch protection of the *status quo*.

The representative body were of an altogether different mind. Rejecting the council's motion, they voted to replace it with minute 45. This stated that practitioners who refused to divulge information without patient consent, except where required by statute law, should receive the support of the full power of the BMA. Such a policy would allow challenges to the absence of the privilege to protect medical confidentiality in the witness-box which, as previously noted, was a common law precedent dating back to the Duchess of Kingston's trial. Elliot's court appearance had raised the hackles of the BMA membership who were of opinion that doctors should not be forced to divulge in court. A resolution was passed making clear the extension of the position.¹⁷ However, as the resolution had not been published in the *BMJ* two months prior to the meeting, Hempson indicated that it could not be adopted as BMA policy. A further resolution was duly passed urging that the council should act upon minute 45 as a resolution of the representative body and submit it to the next representative meeting with the view to it becoming fixed as BMA policy.¹⁸ The council had no option but to refer the whole question back to the CEC.

With the prospect of a more confrontational policy than they had intended prior to the Newcastle ARM, the CEC had to consider the consequences of the post-Newcastle position. While doing so they received a relevant enquiry from Dr Burton, the medical officer of health for the Ilford Urban District Council who had been forced to produce the notification of birth card in the *Devonshire v Devonshire and Eve* case in February 1921.¹⁹ In June the Ilford Council had sought advice from the Ministry of Health on how to address the confidentiality issue involved in local

¹⁷ Minute 48 of the ARM Newcastle 1921

¹⁸ Minute 51 of the ARM Newcastle 1921

¹⁹ BMA CEC minutes Burton to BMA 25 October 1921.

authority officials being subpoenaed to give information in court. Initially the Ministry had reiterated their standard advice to plead privilege and be directed by the judge. When further prompted by Ilford Council, the Ministry had stated that any further protection would require legislation. This was unlikely to be forthcoming and they were unable to agree with Ilford Council's proposal that all local authority documents should be protected on grounds of secrecy. Burton's letter to the BMA included correspondence showing he had taken the matter as far as was possible in a local context, and he was keen to know if the BMA could suggest any other method for dealing with such a problem in future.

The CEC's reply, reiterating the complexity and difficulty of the question - a standard addendum for both the BMA and the Ministry at this time - stated that, with the whole matter under consideration, the BMA was currently being guided by the representative body's resolution from the annual representative meeting in 1921.²⁰ Burton was incensed by this reply. He felt that the CEC had no understanding of the question from the medical officer of health's point of view. The simple requirement was that official documents in their possession were given the same recognition of privilege as was given to documents held by other government offices. The CEC were going about things in the wrong way. If documents which were compulsorily given to a medical officer were not awarded a privilege of confidentiality, then it was unlikely that general practitioners would be given concessions regarding the production of other, non-compulsory, documents. Burton pointed to Dawson's proposed motion to the House of Lords which the government had persuaded him to drop temporarily, leading to fears that the whole question would be 'conveniently shelved'.²¹ Burton hoped that there were enough medical men in the House of Commons to ensure that this would not happen. Thus, it is clear that Burton was keen on the possibility of legislation being debated in parliament, a point of view that was certainly not in line with the thoughts of either the Ministry of Health or the CEC by mid-1921.

With pressure clearly mounting, the CEC sub-committee met in early December 1921. The meeting examined a memorandum written by Langdon-Down aimed at providing focal points for discussion, and clarifying the post-Newcastle position. The intention behind resolution 48 differed from that behind the council's proposed position inasmuch as it aimed to establish a new principle which:

²⁰ BMA CEC SSC minutes BMA to Burton 10 November 1921.

²¹ BMA CEC minutes Burton to BMA 10 November 1921.

if the speeches and feelings manifested at the Representatives Meeting may be taken as a guide, is, that absolute inviolability shall be accorded to professional confidences, whereas no such intention was in the mind of the Council in the early part of this year.²²

Despite disagreeing with resolution 48, Langdon-Down recognised that the Association would be bound by it for the year. Moreover, council was obliged to resubmit the same resolution to the following annual representatives' meeting with a view to it becoming the established BMA policy. *Needham v Needham* had ended with Elliot caving under pressure from the court to break confidentiality because he was not guaranteed support for himself and his practice. If a similar case were to arise under the position adopted by the representative body in 1921, the member involved *would* be guaranteed the full support of the BMA, presumably making a test case a more feasible possibility. However, simultaneously the whole question of confidentiality was being politically sidelined by the withdrawal of Dawson's motion in the House of Lords. While resolution 48 was to be resubmitted to the 1922 annual representative meeting, it was possible for the council to offer alternative resolutions. Having seen their proposals thrown out in Newcastle, and given the practical implications of resolution 48, the CEC felt it wise, yet again, to reconsider the whole question as a matter of principle.

Fundamentally, all were agreed that patient information should not be divulged. The professional position of the medical practitioner placed him in circumstances where he obtained private and intimate information about patients in order to provide them with the best advice and treatment. Such information was given on the tacit, or expressed, trust that it would not be further broadcast by the doctor, which in Langdon-Down's opinion was the reason that any breach of confidentiality met with fierce opposition. In his own words:

²² BMA CEC minutes 5 December 1921.

the strong feeling that the doctors hold about this is just due to this, that it hurts the deepest feelings of decent honourable men that they should divulge information received under such circumstances.²³

Such obvious reference to the medical man as a decent and honourable individual mirrors the picture so vividly painted by Caesar Hawkins in the Duchess of Kingston Trial 1776. Furthermore it confirms that doctors' still saw the question primarily as one of duty. The potential detriment that any perceived breach of confidence would have on the willingness of people to seek treatment and the implications for public health were, in Langdon-Down's eyes, subsidiary claims. He cited the relevant section of the Hippocratic Oath, concluding that these guiding principles were so much a part of daily practice that it was a shock to the practitioner to find that there were exceptions to it. But exceptions there were, both by act of parliament and also 'as a matter of history the demands of the Court have been greatly acceded to for 150 years past in the public interest and without a sense of dishonour to the profession'²⁴ – another clear reference to the Duchess of Kingston Trial, with the emphasis firmly placed on honour.

It was generally recognised that no change could be brought about in statute, and Langdon-Down believed that the representative body's desire to make professional privilege absolute would have to be sought through public support for the position leading to a change in custom. In other words they would have to set a new common law precedent. While recognising the power of custom, he pointed out that the profession had been against the notification of infectious diseases when it was first introduced but had changed its attitude over time. In the same vein, the question of professional secrecy had been reopened by another infectious disease, VD, the dire consequences of which had led a section of medical opinion to believe that it, too, should be notifiable in the interests of public health. But the outrage which had been sparked amongst the profession by the legal cases earlier in 1921, was caused by the stark realization that the rules laid down by a government department, for the working of a VD clinic, had no more legal authority, without an act of parliament to back them, than the rules of professional secrecy which generally guided the medical profession

²³ Ibid.

²⁴ Ibid.

Langdon-Down recognised that the question boiled down to a conflict of duty to the patient and to third parties, notably the state. In court, the practitioner should follow his own belief and convictions in deciding what action to take. If he disclosed at the demand of the court, he would do no dishonour to himself or his profession. If he chose not to disclose, he should explain his reasons to the court. Recognising that there were exceptions to the rule of professional secrecy, Langdon-Down believed that the judge, rather than an outside body like the BMA, was best-placed to decide when medical evidence was material to a case.

The idea that patients would boycott treatment *en masse* unless the state granted the medical profession absolute privilege was, in Langdon-Down's view, unfounded. If doctors gossiped about patients it would undermine trust. But to see confidentiality broken for the purposes of giving evidence in a small number of cases in court would have a negligible impact on the number of patients seeking treatment. If legislation protected the proceedings at VD clinics, there would be growing pressure to extend its application beyond this group of patients, and a law advocating absolute confidentiality could have dire consequences for the profession. Such a law was in force in France and, Langdon-Down believed, medical practitioners objected strongly to it, fearing that wrong-doers could use a medical man as shield and accomplice. It would be much more sensible to make clear to the public that proceedings at VD clinics were no more confidential than normal doctor - patient consultations.

The medical profession should not seek privilege in order to be perceived as having equal status with lawyers or the clergy. Medical evidence was of undoubted value in court, and any claim should be based on much more 'public spirited motives'.²⁵ Referring to the *Kitson v Playfair* trial, he suggested that, rather than being a legal endorsement of medical secrecy, the high damages which had been levied against William Smoult Playfair had been a result of the injuries which he had caused to Linda Kitson, not punishment for a breach of professional confidence. This view of the decision was contradictory to the interpretation that would be adopted by the BMA professional secrecy committee in 1922.

The chairman of the BMA council, Robert Alfred Bolam, believed medical practitioners should not be compelled to divulge patient information in court. For

²⁵ Ibid.

Langdon-Down, this position would not only be largely against the public interest, but would also be the most invidious one for the medical practitioner. As the law currently stood, a practitioner contravened the law if he chose *not* to disclose patient information in court. Such action demonstrated a courage of conviction, even if found to be wrong. However, if the position was reversed and the practitioner had actively to contravene the law in order to make a disclosure, then mistakes would prove much more costly for the doctor who could have kept his patient's confidences at no risk to himself. In addition to this Bolam's position would take the decision as to what was in the public interest away from the public figure of the judge, and place it on the individual private practitioner.

Langdon-Down advocated that the public should be more clearly informed that while medical practitioners were bound by a strict rule of confidentiality, it was not absolute. If the widespread coverage of controversial cases in the press was not enough to draw the public's attention to this fact, then the BMA's discussion, and publication, of resolutions which emphasised that no *voluntary* disclosures should be made, would alert them to the exceptions. By proceeding along these lines the public would become aware of the limitations to the rule of medical secrecy, and when doctors were forced to divulge information, there would be no dishonour to themselves or their profession. Those who wished to challenge the common law hoped to be seen as martyrs for the cause:

the public which might be moved to sympathy by spontaneous individual self-sacrifice on the altar of principle would be equally moved by organised martyrdom with the support of the Association.²⁶

Public opinion was a powerful weapon and if the public was anxious to support the profession on the subject of confidentiality it could make its voice heard. But, in Langdon-Down's view, it was not just the public's support that seemed lacking: 'Ministers who were so eager to act, draw back and common sense asserts its way.'²⁷

Langdon-Down suggested the CEC should prepare a report for the council stating that while it firmly upheld the traditional rule of professional secrecy it recognised that there had to remain exceptions to it. In other words, Langdon-Down

²⁶ Ibid.

²⁷ Ibid.

was aiming at a compromise which stressed both the importance of the doctor's duty of confidence and the need to take account of the consequences of maintaining or breaching confidentiality. The CEC would suggest that the BMA should not preemptively ban or oppose all future legislation, as was implied by minute 48, for the simple reason that such measures may be in the public interest. Rather than seeking to set a new common law precedent on medical privilege, the BMA should aim to assert, to the public and the authorities, the importance of medical confidentiality and emphasise that breach of confidence should only be required in extreme circumstances. This could be done by giving BMA support to practitioners believed to have been unreasonably dealt with, regardless of whether in a civil or criminal case, after due consideration of all the circumstances. As a start in clarifying the position, and consistent with the demands that were coming in to the Ministry of Health, the pledge of secrecy in the advertisements for VD clinics should either be withdrawn or have its limitations clarified. In accordance with all the above points, Langdon-Down believed that minute 48 should be amended.

Langdon-Down's memorandum resulted in five proposed resolutions. The first acknowledged that from the widest view of the public interest, both social and medical, there had to be exceptions to the general rule of professional secrecy. In order to safeguard the honour of the profession, the existence of exceptions to medical confidentiality had to be made clear to the public by giving, where possible, definitions of the exceptions. In recognition that there were exceptions to the rule of secrecy, the second resolution stated that the BMA should not adopt a policy which promised indiscriminating and unquestioning support to any member who disobeyed the order of a court. Consequently, minute 48 should not be confirmed. The third proposal indicated that the principle of professional secrecy should be maintained on the highest possible level with the widest view of public interest. If a case arose in which a member was called upon to disclose information obtained in the exercise of his professional duties, which was, in the opinion of the council or the CEC, contrary to the highest public interest, the BMA should support that member with its full power. Such support would take the form of awakening public opinion to the injury that was ~~threatened~~ to the public interest, and organising it in defence of the doctor.

Resolution four stated that it was undesirable to move in a direction which might result in an absolute imposition of medical confidentiality on doctors. It was

also undesirable that rules on confidentiality, such as those governing VD clinics, should be given legal backing. Rather, if retained, such rules should be accompanied by an explanation that they were subject to the exceptions which applied to other medical secrets. The last resolution simply stated that if resolution two was rejected, then minute 48 should be amended by deleting the word "already". Essentially, this would leave the acceptability of future legislation, which challenged the boundaries of medical confidentiality, still open to debate by the BMA, as and when it arose.

A second meeting of the SSC took place in December 1921 at which a memorandum by Francis Crookshank was received. In addition to his role as a member of the CEC and later the BMA professional secrecy committee, Crookshank was vice-president of the medico-legal society. No doubt with Burton's query after the *Devonshire v Devonshire* case in mind, Crookshank raised a key point which had not been sufficiently dealt with by Langdon-Down. It noted that new forms of information gathering were challenging the established practice of the courts. By statute, and on threat of penalty, individual members of the public were compelled to give information, affecting their private interests, to public officials. According to the developed pattern of legal practice, such information could then be demanded in court, and medical practitioners be compelled to give it, even for only private interests. Whether this position was in the public interest was a matter for debate. In Crookshank's view, a distinction should be drawn between information voluntarily given to a private practitioner and information imparted, either by statutory compulsion or under a pledge of secrecy from a public body, to a doctor acting as a public official. Crookshank was keen to point out that the problems raised were not simply narrow questions of professional privilege but rather wide questions of public policy and public right. This was an important point, noting, as it did, the growing influence of state interest in medical information. Since the introduction of National Insurance, doctors were finding it increasingly difficult to maintain complete independence from state concern. The early twentieth century doctor had a duty to pass on information about births, deaths, infectious diseases, criminal abortions, the incapacity of insured workers and the medical records of insured patients for statistical purposes. Thus, Crookshank was indicating that the question of medical confidentiality went right to the heart of the medical profession's role in twentieth century medicine.

The CEC subcommittee accepted both Langdon-Down and Crookshank's memoranda with a few amendments.²⁸ The most significant change to the Langdon-Down's proposals was the complete omission of one of the proposed resolutions. The standing subcommittee had backed away from resolution four:

That it is undesirable that steps should be taken that might lead to the imposition of the duty of secrecy on the profession by law and that consequently it is undesirable that rules such as those governing the procedure at VD clinics in this matter should be given the force of law and if they are retained it is desirable that they should be accompanied by an explanation that they are subject to the exceptions which apply to other medical secrets.²⁹

This was a significant omission and there was no explicit explanation given as to why it was left out. It is probable that, having found the recommendations put forward by the council to the ARM of 1921 so out of touch with members' thoughts on the matter, the CEC subcommittee were reluctant to fly in the face of the stated opinion of the masses. The four resolutions they were recommending clearly advocated a more moderate position than that proposed by resolution 48. They noted a general rule of secrecy which had necessary exceptions, which in itself entailed that the BMA could not, indiscriminately, give its support to members who disobeyed a court's ruling to disclose information. Support would be given, where considered appropriate, to aid a practitioner who had acted in the best interests of the public. These were general resolutions backed up by claims of best interest to the public. But, proposed resolution four had gone right to the crux of the controversy of medical confidentiality in 1921. It dealt not only with the question of gaining recognition for medical privilege in court - the topic of Dawson's sidelined motion in parliament and the demand of the 1921 annual representative meeting - but also with the controversy surrounding the rules of confidentiality governing VD clinics. This was the very issue that had triggered the early interwar debate on medical confidentiality.

The CEC passed its recommendations on to the BMA council and, in early March 1922, a special meeting of the council was held. The key points for discussion

²⁸ The key points of Crookshank's memo were included as qualificatory notes to the proposed resolutions.

²⁹ CEC Minutes 19th December 1921.

centred on the divergence between the resolutions passed at the annual representatives' meeting in Cambridge, 1920 and that in Newcastle, 1921. Such differences had to be cleared up and a clear notion of the BMA's position, particularly with regard to the conditions and extent of the support it would give its members, had to be agreed before the ARM in Glasgow 1922. Two distinct sides emerged during the meeting. Langdon-Down put forward the views of the CEC, summarizing the arguments developed in their December meetings. He placed particular emphasis on the need to make patients aware of the limits to confidentiality and to remind doctors that secrecy was claimed in the public's interest not the profession's. The French penal code prevented doctors from disclosing information, a system which many French doctors found 'irksome.'³⁰ He concluded by reiterating his opinion that the judge was best placed to decide whether or not a doctor's evidence was necessary. However, he recognised that judges were not infallible, and that provision would have to be made for cases where 'judges misunderstood their function.'³¹

The members of council present were not enthused by the CEC's proposals. Ernest Fothergill saw no dissonance between the 1921 and 1922 resolutions. Fothergill was a long-serving member of council and a constant thorn in the side of the CEC. His proposals on confidentiality had a tendency to conflict with CEC recommendations. He regarded resolution 48 as little more than a rider to the resolution passed by the 1920 annual representative meeting. Nobody would expect the BMA to give its support to anyone who flippantly refused to give evidence, but only in circumstances where it was a clear matter of conscience. If this was accepted, the question was the extent to which the Association would be willing to support such a practitioner. Naturally, in Fothergill's opinion, such support would have to be financial – providing for the practitioner's family, maintaining his practice, and enlisting public support for his cause.

This motion was seconded by Guy Dain. Dain was, in 1922, at the outset of a long and successful career in the BMA. Serving on many committees, he went on to chair both the representative body and council, and was a direct representative to the GMC from 1934 – 1961. He was also a member of the Council on Medical and Allied Services and had supported their majority resolution, given to the Ministry of Health in July 1921, that doctors should not be compelled to disclose patient information in

³⁰ BMA CEC Minutes 31 March 1922.

³¹ Ibid.

court (c.f. chapter 4). Dain drew a clear distinction between medical confidentiality and medical privilege. The former was a general rule not to disclose, while the latter only had relevance in a court of law. If a doctor was to claim privilege it should be for his patient, just as the lawyer's privilege was for his client. The doctor's evidence was more important because it related not only to what he had been told, but also to facts he had learned by virtue of his skill i.e. that a person was suffering from a particular disease. He disagreed with Langdon-Down's opinion that the judge was best place to decide whether medical evidence should be disclosed. Dain felt, in many cases, the doctor was best placed to weigh up the potential benefit the evidence would have relative to the detriment it would cause the patient. While agreeing that the BMA should not advocate absolute privilege on all occasions, Dain felt there were cases where the evidence practitioners were called on to give was of relatively minor importance. In such cases, the doctor's refusal to disclose should be upheld.

Dawson was a further supporter of Fothergill's motion. He believed that there had been some confusion between confidentiality and privilege. The question was whether the medical profession was going to insist upon a form of privilege over and above that accorded to a member of the public. Dawson believed that doctors should demand a measure of special privilege, though in the interests of the state, this should not extend to absolute privilege. He suggested that the limits and applications of the privilege should be discussed by medical and legal representatives, but noted that, while his legal friends tended to favour a privilege which was only applicable in civil cases, Dawson himself did not favour such a clearly drawn distinction. He had no qualm in stating, quite frankly, his opinion that lawyers had carved out for themselves an 'astonishing measure of privilege'³² which had smoothed the legal profession's procedure and secured its place. The priestly privilege derived from the distinction that was maintained between the priest in his religious capacity and as an ordinary man. What he learned in the former he felt justified in asserting he did not know in his latter capacity. No judge would run counter to such a claim. Yet, by virtue of their work, doctors were even more involved with the intimacies of human life, receiving secrets relative to a patient's health and otherwise. Dawson painted a vivid picture of a patient lying on his sickbed, unburdening his mind by confessing certain secrets to his medical attendant. These, not infrequent, confessions were made in moments of

³² BMA CEC Minutes 31 March 1922.

weakness and they should be protected by a special privilege granted to medical practitioners in courts of law. Dawson requested a 'strong, unequivocal'³³ statement on these lines from the BMA.

Dawson's remarks found support from James MacDonald. MacDonald had been chairman of the BMA council from 1911 until 1920 when he was succeeded by Bolam. Like Dawson and Dain, he was a member of the Council on Medical and Allied Services and had supported their majority resolution in July 1921. MacDonald explained that he would be prepared to go further than most in exalting the interest of the individual patient, even above public interest, in the cause of medical confidentiality. Henry Brackenbury, a future chairman of both the representative body and council, was somewhat more reserved. He indicated that the Newcastle resolution's call for a guarantee of unlimited support for a practitioner who refused to disclose in court was excessive. He wished the circumstances and extent of support to be clarified, as well as a more exact definition of when it was correct to disclose. This latter point was perceived, by Sir Thomas Jenner Verrall, as being an exceptionally hazardous route to take. Verrall, who served on the BMA council from 1893 until his death in 1929, felt that the decision had to be left, to some extent, to the circumstances of each case as it arose.

Carrying on the theme of circumstances, Charles Buttar, the representative member for Kensington, reiterated those in which the ARM in Newcastle had arrived at the controversial approval of resolution 48. Stimulated by the very recent events of the *Needham v Needham* case, the RB had passed a strong resolution which might, now that more consideration had been given to it, require some modification. Buttar believed that there was no middle course to be followed: either the profession contended for an absolute principle of professional secrecy or they ceded the question by default. He pleaded that the BMA stand by the principle of absolute inviolable secrecy, suggesting that if it were necessary for medical men to stand in contempt of court in nine out of ten cases, the resultant protest would be so great as to ensure they did not remain under duress for long.

Bolam, the chairman of council, indicated that a committee might be set up to consider the matter. This view was supported by Edward Turner (of bicycle seat fame) who suggested that a small committee would have a better chance of arriving

³³ Ibid.

quickly at one clear-cut and decisive recommendation. As far as the general law of evidence went, he believed that conscience should be the guide as to whether or not disclosures were made. However, doctors should still respect statutory obligations to disclose information 'for they did not wish to be anarchists.'³⁴ The council unanimously agreed to refer the matter back to the CEC for further discussion and a more exact formulation of the 'conditions under which, the extent to which, and the ways in which the Association would be willing to support any of its members who refused to divulge.'³⁵ The CEC was to be bolstered for this purpose by the co-operation of the aforementioned speakers (Dawson, Turner, Verrall, Dain, Fothergill, MacDonald). Bishop Harman³⁶ suggested that the extended CEC should carefully consider a recent article by William Brend in the *BMJ*.³⁷ In this manner, the CEC was augmented and evolved into the BMA Professional Secrecy Committee which met for the first time in April 1922.

Summary of position in 1921

Clearly then, 1921 was a trying year for the BMA and its policy on the question of professional secrecy. The case of *Needham v Needham* had brought a huge amount of publicity to the question of confidentiality, or rather the obvious lack of it for patient information when demanded as evidence in court – even when such information had been given under an expressed, and widely advertised, pledge of secrecy. Its timing, falling as it did just before the ARM at Newcastle, brought a backlash of opinion. The RB voted to disregard the considered advice of the CEC and the Council, and adopt a far more extreme position which called for the recognition of an absolute privilege of confidentiality, except in matters already covered by statute. They further demanded the full, unquestioning, support of the BMA for any member who fell foul of the system as a consequence of maintaining this position. The result, resolution 48, was referred back to the CEC for debate, on the understanding that it was to be resubmitted to the ARM in Glasgow 1922, where its acceptance would result in it

³⁴ BMA CEC Minutes 31 March 1922.

³⁵ Ibid.

³⁶ Nathaniel Bishop Harman went on to become Treasurer of the BMA and the Association's direct representative on the GMC. Specialising in problems of the eye, he was an advocate of notification of cases of *ophthalmia neonatorum*. He was also the grandfather of the present government minister, Harriet Harman.

³⁷ Brend was trained in both law and medicine and was a lecturer on forensic medicine at Charing Cross Hospital Medical School. His article appeared in the *BMJ* 14 January 1922, 64-66.

becoming the established policy of the Association. This was a clear indication that the more moderate approach being forwarded by the CEC, was not in keeping with the majority of members' opinions in the aftermath of Elliot's highly publicised ordeal in court. In fact, growing discontent characterised the atmosphere surrounding the issue of medical confidentiality throughout 1921. Burton and the Ilford Urban District Council were clearly not satisfied with either the Ministry or the BMA's approach to the whole matter. Furthermore, there were clearly those who felt the opportunity for change was slipping away with the enforced sidelining of Dawson's motion in the House of Lords. Elements of the BMA showed signs of disappointment at the lack of action from 'certain government departments.' The CEC were not impressed by the reversal of the 1920 Cambridge resolution and the widespread support for a position, in resolution 48, which they did not wish to advocate. The divergence of opinion between certain key figures of Council and the CEC was prominent in the special meeting of Council which met to discuss the CEC proposals based on Langdon-Down's assessment of the way forward in early 1922. This dispute resulted in the matter being referred back, once again, to the CEC. But the importance of arriving at a clear policy for the Association, and the pressure of time before the ARM in Glasgow 1922, saw some important characters drafted in to augment the CEC. The Professional Secrecy Committee, as the expanded group came to be known, included both doctors and lawyers, and the members held a wide range of opinions on professional secrecy. It is perhaps of little surprise, then, to learn that, before too long, individuals felt obliged to break away and publicise their opinions elsewhere. In a pamphlet which reprinted a speech on professional secrecy that he had given to the annual meeting of the South Midland Branch of the BMA in late June 1922, Crookshank stated:

'My diffidence in dealing with this subject arises from the fact that, with your President, I have been, until recently, a member of the Central Ethical Committee of the British Medical Association, which, as you know, has given much attention to the questions involved. Unfortunately, I lately felt compelled to dissociate myself from the work of that committee owing to my

inability to find my own views in harmony with the policies advocated by some of those in greater authority.’³⁸

It is to the work of the Professional Secrecy Committee, charged with bringing order out of chaos, that the focus of attention now turns.

1922

The guiding light of conscience.

BMA professional secrecy committee.

Meeting 1

With pressure of time before the annual representatives’ meeting in Glasgow, the first meeting of the professional secrecy committee took place at the end of March 1922. The committee members were to discuss the CEC recommendations which had been put forward to the council, two further memoranda, one from Fothergill and another from Dain, and Brend’s article in the *BMJ*. Specifically, the committee was to focus upon the extent to which, and the ways in which, the BMA should support any of its members who refused to disclose medical information in court. Other than the specific emphasis on the doctor’s obligation in court, the remit matched the one given to the BMA council by the representative body at Cambridge in 1920 – testament to the frustrated efforts of the BMA to achieve any semblance of progress towards a fixed policy for the guidance and support of its members in the intervening period.³⁹ Yet, time was of the essence, as the council wanted a final report before its meeting on the 26 April.

Fothergill’s memo was first. As he had made clear at the special meeting of council, he did not agree with the recommendations which the CEC had put forward, and he advocated their rejection.⁴⁰ He believed that the CEC’s recommendations had been formulated in order to establish the law in the strongest possible position and that they failed sufficiently to take into account the situation which had arisen in the 1921 annual representatives’ meeting. He re-iterated his belief that the Cambridge and Newcastle resolutions were not antagonistic. By suggesting they were, and believing the desire for privilege to have stemmed from ‘professional dignity, pride and

³⁸ F G Crookshank, *Professional Secrecy*, (London, 1922), 3.

³⁹ ARM 1920 Min.76

⁴⁰ His objections were split into those which he saw as fundamental objections and those which were concerned with detail. Only the former will be given overt consideration here.

jealousy'⁴¹, the CEC had disregarded it and stressed a more moderate position. But, given the strength of feeling expressed at Newcastle, the CEC's attempt to return to the earlier position threatened to set the debate on to a circular trajectory.

This, in Fothergill's opinion, was wholly avoidable as the CEC's report had unwittingly given the solution to the confusion over professional secrecy: *conscience*. In 1896, Justice Ivory had called the same factor 'discretion'; a report of the CEC had also referred to it as 'moral obligation'; and, in order to sum up the collective meaning of these terms, Fothergill cited the words of Tredgold :

The quality of mind which enables a man to feel that he has obligations to society which makes him sensible of the ideals of honour and honesty; of compassion and chivalry; of patriotism and altruism; and which not only restrains the individual from doing wrong, but impels him to do right.⁴²

Fine words indeed, but in the complex world of practical ethics, a phrase such as 'patriotism and altruism' could pull the doctor who wished to serve both state and patient, in opposite directions. Fothergill suggested that resolution 48 should not be interpreted as giving *carte blanche* to members to disregard the demands of a court. Rather, no support should be expected, or given, to a practitioner who refused to disclose from a desire to flout the court or appear heroic. The backing of the BMA should only be given to practitioners who had weighed the matter carefully and acted in the interest of the current patient and other patients' future concerns. Fothergill's intention was quite clear. He wished to separate out the egotistical attention seeker from the principled crusader, but beyond this broad division it is difficult to see how the latter half of the sentence could be interpreted by a practitioner who found himself in the middle of a case where both parties were patients of his. Presumably, the interest of one patient did not always equate well with the interests, future or otherwise, of other patients.

Fothergill turned to Brend's article on professional secrecy. This set out four conditions which should be fulfilled before the BMA provided support to a member

⁴¹ This remark, made by Langdon-Down was quoted by Fothergill. BMA Professional Secrecy Committee minutes 31 March 1922.

⁴² BMA PSC minutes 31 March 1922.

who refused to give evidence in court.⁴³ Firstly, communications must originate in a confidence that they would not be disclosed. Secondly, the element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties. Thirdly, the relation must be one which, in the opinion of the community, ought to be sedulously fostered. Lastly, the injury that would result to the relation by disclosure of the communications must be greater than the benefit thereby gained for the correct disposal of litigation. Fothergill proposed an addition to Brend's four criteria, namely, that the doctor in question would be required to decline the court's request in a phraseology approved by the annual representatives' meeting. He believed that the declaration could follow the lines of that used by the French:

That as the facts on which he is being interrogated were brought to his knowledge whilst acting in his professional capacity and therefore were obtained in confidence he, in the exercise of his conscience finds himself unable to disclose them without his patient's consent.⁴⁴

These were hardly revolutionary words, having been the standard advice given out by the BMA and Ministry of Health for over two years. Fothergill's next step was to outline the forms of support that a practitioner who fell into difficulty with the court, as a result of following the above advice, would receive from the BMA. Support was required on three fronts. Firstly, there was the tricky issue of finance. In no doubt of the scale of the problem, Fothergill questioned whether the funds of the BMA could be used, or if a separate fund which demanded a subscription based upon a percentage of each member's practice, would be required. Secondly, on a local level, each branch would have to have a centrally approved system of support in place, in order to continue the work of a member's practice during any period of imprisonment. Lastly, on a central level, the medico-political committee could educate and focus the press, public, legal and government opinion in favour of the member, whilst also aiding the local branch in the maintenance of the member's dependants and practice. Having taken account of all his proposals, Fothergill believed the BMA would then be in a position suitably to amend resolution 48 for resubmission to the annual representatives' meeting in Glasgow and that, either before or afterwards, a

⁴³ *BMJ* 14 January 1922, 66.

⁴⁴ BMA PSC minutes 31 March 1922.

committee of medical and legal practitioners, along with some laymen, should be formed to discuss the whole medico-sociological question.

Next on the meeting's agenda was Dain's memo. The maintenance or violation of professional secrecy was, in his opinion, a moral issue and consequently should be a matter for individual conscience. Distinguishing between the general rule of medical confidentiality and the question of medical privilege, Dain accepted that there were exceptions, statutory and moral, to the former. In the case of medical privilege he drew attention to the acceptance of a level of privilege for both priest and lawyer. The high profile cases in which doctors had been forced to break professional confidences in the early 1920s had made it clear that they had no privilege of secrecy in court. According to Dain, when a doctor felt bound by conscience not to disclose, the lack of support from the BMA, evident in the account given by Elliot subsequent to *Needham v Needham*, made it nigh on impossible to resist the court's demands. It was in recognition of the impact that guaranteed support would have on doctors who found themselves bound by conscience to maintain secrecy, that the two previous annual representative meetings had passed resolutions advocating BMA support.⁴⁵

Many had tried to draw a distinction between the according of medical privilege in civil cases, but not in criminal cases. In the latter, the state required the violation of secrecy for the purposes of justice in the detection of crime, whereas in the former, one individual was seeking the breach of another individual's medical secrets for his or her own ends. The civil cases in which disclosure was most often required were those involving divorce, and, in Dain's opinion, these could largely be avoided if the law of divorce was altered to give equality to the sexes. Medical evidence could be used to prove adultery and cruelty in divorce cases, both of which were required for a woman to divorce her husband. But Dain's prediction of a drastic drop in the demand for medical testimony, if women had parity in divorce proceedings, was perhaps over optimistic. Certainly the cases which had aggravated the question of medical confidentiality in the immediate post-war period had centred on medical evidence in civil divorce hearings. Yet, husbands had demand of doctors' testimony to prove the adultery of their wives. John Elliot had been subpoenaed by the husband in the *Needham v Needham* case, who wanted to prove his wife's

⁴⁵ Minute 76 of the 1920 meeting in Cambridge and resolution 48 of the 1921 meeting in Newcastle.

adultery.⁴⁶ Parity in the divorce law might reduce the number of cases in which medical evidence was demanded but it would by no means eliminate the problem.

Dain disagreed with Langdon-Down that the judge was best placed to decide whether a patient's confidence was to be betrayed. A judge could regard the doctor's testimony as an easier method of establishing facts, which could be proved in other ways, without considering the damage to public confidence in the medical profession. In other words, Dain was sceptical of judges always weighing the pros and cons of requiring the breach of medical confidence in court, particularly when a doctor's testimony could save the court time and bother. Dain's final point related to the semantics of resolution 48. He noted that it committed the BMA to use all its 'power' *not* 'resources', which suggested, to him at least, that the support would not be monetary but rather would equate to influence at a local and central level. Thus, like Fothergill, Dain interpreted resolution 48 as being applicable only to *bona fide* members who based their refusal to disclose on a conscientious belief, in keeping with the essentials laid down by Brend's *BMJ* article. However, unlike Fothergill, Dain clearly did not feel that the BMA support should take the form of financial aid.

Dr Stevens put forward two notices of motion to be considered. Firstly, he suggested that a practitioner was not justified, without the patient's consent, to disclose, even in a court of law, professional confidences which might damage the good name or reputation of the patient, or might involve him in any harm other than of a purely financial nature. In cases where a refusal to disclose was considered to be justified and yet the practitioner still fell foul of the court, Stevens urged the BMA to make suitable representation to the Home Office, and ventilate the issue in the *BMJ*. Secondly, he suggested that the Hippocratic Oath should be published in the *BMJ*, along with examples of the forms of obligation which medical graduates were required to subscribe to in universities and colleges in England, Scotland and Ireland. Clearly then the *BMJ* was once again being invoked as a strong weapon in the debate on confidentiality. However, it is also interesting to note the specific exclusion of financial harm from the justifications for protecting a patient's confidences. Argument was made in chapter two that the doctor's ideals of honour were not always easily distinguished from his financial interests, and here Stevens drew a clear distinction

⁴⁶ In Scotland *ophthalmia neonatorum* was a notifiable disease. See R Davidson, *Dangerous Liasons. A Social History of Venereal Disease in Twentieth-Century Scotland*, (Amsterdam, 2000), 178; J Jenkinson, *Scotland's Health 1919 – 1948*, (Bern, 2002), 164.

between the hurting of a patient's reputation and damage done to his financial interests. Stevens was emphasising that reputation mattered, money did not – at least as far as patients were concerned.

Having considered the report of the proceedings of the special council meeting, the memos from Fothergill and Dain, the article by Brend, and the notices by Stevens; Dawson proposed the following motion:

That the proper preservation of professional secrecy necessitates a measure of privilege being recognised for medical witnesses in Courts of Law above and beyond what is accorded to the ordinary witness.⁴⁷

The proposal was unanimously resolved. Crookshank proposed that the term 'privilege' should not be construed as meaning 'legal privilege'. After considerable discussion this was withdrawn and replaced by a further proposal by Crookshank that the term 'privilege' should be construed as meaning 'legal privilege'. Wallace Henry put forward an amendment which clarified that the measure of privilege aimed at was that no registered medical practitioner would be compelled to disclose professional confidences without patient consent. The amendment was carried, also as a substantive motion, by ten votes to four. Clearly then, despite many months of focussed discussion, the select membership of the professional secrecy committee were having difficulty establishing exactly what the privilege, which they all wanted, actually was. Unanimity was restored with a proposal by Arnold Lyndon. Lyndon joined the BMA Council in 1922 and served on it until 1935. He also served on the Council of the Medical Defence Union and on the Standing Joint Committee of the MDU and Medical Protection Society. He suggested that for the time being the BMA should support in every way possible any member who, in the opinion of the council or the CEC was considered to be justified in refusing to disclose professional confidences. It was further resolved that Stevens' motion for the publication in the *BMJ* of the Hippocratic Oath and the examples of forms of obligation should be forwarded 'for the favourable consideration of the Editor.'⁴⁸

In agreeing with Lyndon's proposal, the PSC seemed to be broadly agreeing with the representative body's feeling as expressed in resolution 48, but with two key

⁴⁷ BMA PSC minutes 31 March 1922.

⁴⁸ Ibid. The editor at the time was Sir Dawson Williams.

exceptions. Rather than the having the possibility of unqualified support for any BMA member who refused to breach secrecy in court, which resolution 48 technically permitted, Lyndon's proposal only granted support where an arbiter deemed the member's actions to have been justified. This led, naturally, to the second qualification - that the arbitration of whether a member's actions fell into the 'justified' category should be undertaken by the council or CEC. If accepted, this would not only remove the potential threat of indiscriminate demand on the BMA's resources, but it would also place control of the BMA's policy on confidentiality firmly back into the more conservative hands of the council and CEC.

Meeting 2

The next meeting of the professional secrecy committee took place a week and a half later with only a fortnight left before the council deadline. Brend had been asked to furnish the committee with information relative to the privilege granted to doctors in certain states in America, particularly focussing on the objections which had been made to the privilege, and who had made them. After the unanimous acceptance of Lyndon's proposal at their previous meeting, Alfred Cox had drawn up a draft report of Council to be considered before being put to the 1922 annual representatives' meeting. There were also memos from Fothergill and Hempson.

Cox's draft report examined whether the claims of communal interest, as expressed by a judge, overrode those of the individual patient. The BMA council supported the representative body's belief that it was in the best interests of the community, and in keeping with the best traditions of the medical profession, to support a medical practitioner who refused to give out information without patient consent. The position adopted was long standing, having found expression in the Hippocratic Oath, and had even been 'fitfully' endorsed by the law when it awarded high damages to patients whose confidence had been violated – presumably a reference to *Kitson v Playfair*. The BMA had always resisted suggestions by the law, that doctors should use their position to aid the justice system by providing information on criminals, particularly those involved with abortion. Their grounds for resisting the law's advances were simply that

for the good of the greater number it is essential that nothing shall be done to prevent persons who are ill from consulting doctors in the fullest confidence

that their secret, even if it be that they have connived at the commission of a crime, is safe with the doctor.⁴⁹

Such firm assurance of the sanctity of the doctor - patient relationship, even in the context of past crime, is strongly reminiscent of the Royal College of Physicians' discussion with Avory and Clarke, and Saundby's comments in *Medical Ethics* which had incurred the wrath of the law in 1915. This represented a return to a more fundamental position than the BMA council or CEC had shown since the 1915 confrontation. Having launched out to a strong stance against the law in the pre-war debate the higher echelons of the BMA had recoiled to a more moderate position in the discussion of the early 1920s. The draft report was even keen to point out that the notification of infectious diseases, while recognised as the only exception to confidentiality, placed the responsibility on the relatives and friends of the patient as well as the doctor, to notify the authorities. Furthermore, the law of notification was well known, so, implicit consent to notification could be taken from the patient's willingness to consult medical opinion.

Seemingly advocating a strong stance in favour of maintaining medical confidentiality, the draft report then muddled the issue by stating that everyone was aware that there were occasions on which individual practitioners would feel their duty to the state or other individuals compelled them to breach the confidence of their patient. In keeping with the opinions expressed by Fothergill and Dain, this was taken to be a matter of morals, governed by individual conscience, and therefore could not be covered by a general pronouncement. Having dealt, in broad terms, with the question, Cox turned to the tricky question of how the general belief in the fundamental importance of medical confidentiality could be reconciled with the right of the state to demand evidence in court. The privilege given to lawyers was required for the legal system to work and so was in the interests of the general public as well as clients. Although there was no official privilege granted to priests, it was generally recognised that the courts understood the importance of secrecy which such men attached to information given to them in their religious capacity. Thus, in recognition that demanding information from priests would only incite a passive resistance 'which

⁴⁹ BMA PSC draft memo council to RB 11 April 1922.

would be stronger than the law'⁵⁰, priests were understood to enjoy a greater degree of privilege, despite the potential detriment to the administration of justice.

The case against medical privilege amounted to the detrimental impact which it would have on the detection or prosecution of crime. Yet, Cox pointed out, the same argument could be levied against the priest and lawyer. The crux of the medical case for privilege revolved around the belief that

It is better that injustice should be done or crime left undetected on rare occasions than that fear of public disclosure should be placed in the way of perfectly free communications between patient and doctor. If this free communication is impeded disease would be left untreated and not only the individual but the community would suffer.⁵¹

The council was aware that there was a conflict of roles between the practitioner as citizen, with his duty to the state, and the practitioner as doctor, with his duty to the individual patient. For this reason, they advocated that there should not be an absolute privilege for the medical profession on a par with lawyers and priests. Rather the conflict of roles could best be resolved by granting a modified privilege which prevented the court from compelling a medical practitioner to divulge information without the consent of his patient. It is not immediately clear as to how this substantially differs from the legal and religious privilege, for presumably neither group would have much difficulty in aiding the demands of justice if their client gave them consent to do so. Indeed, the suspicion that this was more of a comprehensive privilege than the report made it out to be is highlighted by its similarity to BMA council minute 542 of 27 Jan 1915:

The council is of opinion that a medical practitioner should not under any circumstances disclose voluntarily, without the patient's consent, information which he has obtained from that patient in the exercise of his professional duties.

⁵⁰ Ibid.

⁵¹ Ibid.

This, as previously noted, was agreed at a time when the BMA was seeking to establish itself in a strong position in maintaining secrecy against the wishes of the law.

Having established the extent of the privilege which was to be sought, Cox turned to assess the level of support which the BMA would be willing to give its members. The professional secrecy committee had adopted Lyndon's recommendation from the previous meeting. Only individuals who the council or CEC deemed were justified in refusing the court's request, were eligible to receive the Association's support. The criterion for assessing each case was fourfold. The first three were lifted directly from Brend's article in the *BMJ*, but the fourth differed. Brend had emphasised that the injury which the disclosure would cause to the doctor - patient relationship would have to be greater than the benefit of the correct disposal of litigation i.e. the predicted consequences would determine BMA support. The professional secrecy committee argued that the practitioner must persuade the BMA council that the information came to his knowledge in his professional capacity and consequently he considered himself 'morally bound to plead inability to disclose them [the patient's confidences] without his patient's consent.'⁵² This change from Brend's fourth criterion, which had been endorsed by Fothergill at the previous meeting, to the draft report's new fourth criterion, demonstrated a clear shift in the way in which the professional secrecy committee was thinking about privilege. There was a move away from consequentialist arguments which had failed to convince the judiciary that the benefits to public health of maintaining medical confidentiality in court could outweigh the loss of medical testimony to the legal process. The justification for lawyers' privilege was that, without it, individuals could not openly consult legal advisers and thereby it would hinder the effective working of the justice system. A similar argument had been put forward by doctors who argued that privilege was a necessary factor in an effective system of public health. However, instead of modelling their claims on the consequentialist model of legal privilege, the professional secrecy committee was now attempting to align the doctor's position with that of the religious adviser: an individual morally bound to secrecy whose strong conviction of duty made him immune to the discipline of the court. Too late for Elliot of Chester, the BMA was setting a course for medical martyrdom.

⁵² BMA PSC draft memo council to RB 11 April 1922..

Elliot had succumbed to the court's demand because of the absence of practical professional support. Cox's report indicated that support would now be available on three different levels. The local division would be responsible to the Council for successfully maintaining the doctor's practice. The BMA would organise public opinion through the press and parliament. It would also provide legal advice, and their funds would be made available because 'the cases will be test cases on a matter which affects the honour and interests of the medical profession'.⁵³ The draft report ended on a rather positive note, suggesting that any enforced imprisonment of a practitioner 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 reads somewhat like a BMA manifesto for medical martyrdom. Elliot had been willing to endure prison for a short period, and here the council was suggesting that imprisonment would not last long. As well as promising publicity for the cause, legal advice, and the funds of the BMA, additional sources of support could be drummed up as required, so potential martyrs need not worry about any damage to their practice. Indeed, far from proving detrimental, martyrdom would enhance a practitioner's long term prospects, presumably by attracting to his practice patients who had been impressed by his high ethical standards. The similarities, between the underpinning philosophy of these conclusions and Caesar Hawkins' stance in the Duchess of Kingston trial, are stark. Just as Hawkins had used his forced appearance in court to advertise his ethical approach to medical practice, in the full knowledge that such a high profile trial would be closely followed by patients, both actual and potential, so the professional secrecy committee were reassuring members that martyrdom for the cause of medical confidentiality would reap long term benefits for the individual concerned. The promise of the 'organisation of public opinion'⁵⁴ through multiple channels of press and government would do, for the individual involved, what 5,000 spectators and *The Gentleman's Magazine* had done for Hawkins 146 years prior.

Having considered the draft report the professional secrecy committee turned to a memo by Fothergill on the conditions and terms of BMA support for members.

⁵³ BMA PSC draft memo council to RB 11 April 1922..

⁵⁴ Ibid.

Fothergill proposed three additional criteria for support to the four set out in the draft report which the committee had just considered. The first addition placed an obligation on a member who sought BMA support to get in touch with the council as soon as it was likely that he would be called upon to break confidentiality without consent. He would also have to express in writing his agreement to act in accordance with the council's decision. Fothergill's second addition stipulated that the member would have to be a fully paid up subscriber to the medical secrecy defence fund (to be set up) and could not be involved as a defendant in any ethical procedure at any level of the BMA. Lastly, the member would also have to be a member of a recognised medical defence society which could aid him should he feel morally bound to make a disclosure without patient consent.

Unlike the draft report, which advocated the use of BMA funds, Fothergill suggested the setting up of a medical secrecy defence trust fund which would provide financial assistance of up to a year and a half's purchase value of the doctor's practice as assessed by an independent accountant. As Bartrip notes, the significant rise in the BMA subscription charges in 1914 had been a contributory factor to a decline in membership around this time, and the Association's finances had been hard hit by the national health insurance struggle and the First World War.⁵⁵ In order to avoid adding greatly to members' costs, it was proposed that members who paid 3 (or 5) shillings into the medical secrecy defence trust fund before February each year would have that amount discounted from their annual BMA membership subscription. The fund could also be bolstered by a donation from the medical insurance committee and by approach to some of the recognised medical defence societies. Fothergill, of course, would not be aware of the London and Counties Medical Protection Society's request to the Ministry of Health to be recompensed for their financial support of Elliot the previous year. Yet, Fothergill echoed the belief that the financial loss to a temporarily imprisoned practitioner would be both small and consequently offset by a boom in his practice. He also agreed that BMA support should take the form of local support, publicity/opinion support, and financial support for dependants, and suggested resolution 48 should be amended accordingly.

Fothergill's other major point of interest echoed Crookshank's enquiry as to whether a doctor holding a public position should be required to give information in a

⁵⁵Subscription rates rose by 68%, from 25s to 42s. P Bartrip, *Themselves Writ Large.*, 194.

private interest case. Building on what he had stated in his earlier memo, he suggested the forming of a medico-sociological committee to consider this and other questions, and report either to the council or direct to the annual representatives' meeting in Glasgow. If this was not satisfactory, as an alternative, he suggested approaching the relevant departments of government with a view to 'the implied pledge being incorporated in an Act of Parliament and not being left to orders issued by a Department.'⁵⁶ This referred to the regulations issued in conjunction with the government VD treatment clinics, which Elliot had unsuccessfully tried to cite as his justification not to disclose in a divorce case. The judge had ruled that regulations, even when issued by government departments, did not have force in a court of law. Encapsulating the same pledge of secrecy in an act of parliament *would* prevent the forced disclosure of information gained by a doctor working in a government approved scheme, for the private interest of a divorce case. However, as the previous two years had shown, getting a statutory form of medical privilege would be an exceptionally difficult task.

The final item on the professional secrecy committee's agenda was a memo by Hempson. He was at pains to dispel the belief that there was a distinction to be drawn between medical confidentiality and privilege. In his view, what was being sought was recognition, within the law courts, of the generally endorsed practice of doctors maintaining their patients' confidences. There were four stages to the achievement of this objective. Firstly, doctors needed to standardise their position on medical confidentiality. Secondly, the general public had to be made aware of the medical profession's concerted attitude. This, along with its traditional basis, had then to be instilled into the mind of the law. Lastly, support would be needed for members who suffered as 'martyrs to the cause'.⁵⁷

Having set out his thoughts on the way the BMA should proceed, Hempson addressed a point which had, thus far, been overlooked. In formulating their position by consideration of the doctor's obligation to his patient, the BMA had failed to consider the consequences for relations within the profession. Having worked as solicitor to the Medical Defence Union, Hempson had seen many cases where doctors had been cited to give testimony in investigations of malpraxis. If an individual who brought a case of malpraxis against a practitioner had consulted four additional

⁵⁶ BMA PSC Fothergill memo 11 April 1922.

⁵⁷ BMA PSC Hempson memo 11 April 1922.

doctors but only called the two whom he knew would give favourable evidence on his behalf, what would be the position of the two doctors who were not subpoenaed by the plaintiff? Even if subpoenaed to appear by the defendant, it is unlikely they would have the consent of the patient (plaintiff) to give testimony against his case. What advice and support could the BMA offer members in such circumstances? The example seemed to leave the doctor with two options: either breaking the patient's confidentiality in order to give testimony in favour of the defendant (colleague), or maintaining it to the defendant's detriment. In the former case, the profession would be open to accusations of favouritism in relaxing the standards which it applied to itself. In the latter, the proposed rules of the BMA would only permit practitioners to give evidence *against* each other, posing a threat to professional harmony and unity. While the illustration given involved a civil case, the same issues would be raised if a doctor stood trial on a criminal charge.

Hempson foresaw a further difficulty in the BMA's proposed policy. If conscience was the measure of justification for pleading privilege in court and the support or otherwise of the BMA was to be determined by the council in light of the facts of each case, it was feasible that a practitioner could refuse to disclose in court on grounds of conscience, while the BMA council might later disagree with his position. The merits of an act of conscience could at times only be assessed after the event. Moreover, conscience could take different practitioners in different directions. Behind the fine rhetoric of Tredgold's definition of conscience lay the fact that 'in man there are varying degrees of "conscience" according to his birth, his upbringing or his station in life'.⁵⁸ Conscience was not a simple yardstick with which to measure.

In a sub-appendix to the printed minutes of the meeting, Langdon-Down tried to draw together the threads of agreement which had emerged in the professional secrecy committee's discussions. There were four things required. First, the maintenance of the public's interests as patients, although it was recognised their interests as citizens sometimes needed priority. Secondly, they sought the maintenance of professional dignity in court, both in practitioners' actions and in the court's level of respect for doctors. Again, it was realised that the public's interests as patients or citizens was of prior importance. Thirdly, the profession wished to avoid 'being called upon to do

⁵⁸ Ibid.

violence to our consciences, whether in their civic or their professional capacity.’⁵⁹ This simply highlighted the dilemma faced by a profession bound by a strong sense of conscience and duty, caught between the tradition of obligation to private patient and the obligation which the early twentieth century emphasis on collective interest brought. Lastly, anarchical methods of achieving the profession’s goals were to be avoided.

The prolonged debate had brought Langdon-Down to the conclusion that legislation was too rigid and ill-adapted to the ends which the BMA were now focussed upon. Absolute privilege was not aimed at, so the conscientious difficulties faced by practitioners would best be removed by emphasising to the public that medical secrecy was subject to certain reservations. Langdon-Down suggested that a compromise was the best solution. Practitioners’ should not antagonise judges, but make clear to them the importance of maintaining patient confidentiality. Therefore, while the doctor had a duty to disclose medical evidence to prevent ‘grave injury to the State, the patient or other persons’⁶⁰ so judges should recognise a duty on them not to compel a breach of medical confidence unless absolutely necessary. If there was evidence to show that the law was not co-operating, then the matter could be taken back to the law officers of the crown. Thus after vast numbers of memos and proposals, widespread debate, and the setting up of a professional secrecy committee to advise the BMA, the CEC chairman suggested that the solution lay, more or less, with a better advertised version of the status quo. Like siblings arguing over a toy, both would get their turn. But first they would have to learn to compromise.

Sibling rivalry and ‘the spoilt child of the professions.’

Langdon Down’s promotion of compromise no doubt stemmed both from many years considering the question as chairman of the CEC, and from recent events at the Medico-Legal Society. Lord Dawson of Penn had delivered a controversial address on medical secrecy to the Medico-Legal Society in the period between the special meeting of council and the first meeting of the PSC.⁶¹ While much of his speech merely reiterated well-rehearsed arguments over abortion, VD, and precedents from the Duchess of Kingston onwards, he overstepped the mark in his assessment of the

⁵⁹ BMA PSC Langdon-Down memo 11 April 1922.

⁶⁰ Ibid.

⁶¹ *Lancet*, 1922 vol.1, 619.

privilege given to lawyers. Dawson had been keen to point out that medical practitioners' sole aim was gaining privilege in the interest of patients. He saw no such altruism in the law: 'For generations the law has occupied a favoured position; it is, in fact, the spoilt child of the professions.'⁶² Moreover, extension of privilege to the sister profession of medicine was not really opposed because it would be detrimental to state interests but because it would be inconvenient to legal procedure. Such comments turned the debate away from a considered discussion of the problem at hand toward an inter-professional argument which spilled over to a meeting of the society the following week.

The propensity of certain doctors to see the issue in terms of relative professional prestige proved too much for Crookshank. His resignation from the CEC was acknowledged at its next meeting in April 1922. A later communication gives an indication of his reasons: 'I view with very great apprehension certain tendencies which seem to me to be forcing the BMA into an attitude of disharmony rather than of "co-operation", in respect of the interests of the social organism, and particularly, this matter of privilege.'⁶³ Clearly passionate about the issue, Crookshank continued to speak his thoughts – notably at a meeting of the South Midland Branch of the BMA in June 1922 which was later published.⁶⁴

Others were also feeling the heat in the run up to the annual representatives' meeting in Glasgow 1922. While Crookshank's concern was over professional self-interest, Hempson was worried that the medical profession's interests were being overlooked: 'above all things we want to be careful that our altruistic conceptions for the guidance of the profession in aid of the public weal, do not place the Profession itself in circumstances of difficulty...'⁶⁵ Clearly, he felt his point on the doctor's obligation in malpraxis cases had not been satisfactorily resolved. Alfred Cox, having drafted the professional secrecy committee's report to the BMA council, had even graver doubts:

I have never felt less comfortable over anything than I do over this.... I have tried to make it, within the limits of a short report, as convincing to myself and others as I could. But frankly I am not convinced that the line we are

⁶² Ibid. 620.

⁶³ BMA CEC minutes, Crookshank to CEC, 30 May 1922.

⁶⁴ F G Crookshank, *Professional Secrecy*, (London, 1922)

⁶⁵ BMA Correspondence, Hempson to Cox 4 April 1922.

suggesting will stand criticism.... it is quite hopeless to try to build up a series of rules and regulations and to try to make it look watertight. The attitude rests on sentiment and tradition and it is no good trying to invest it with logical consistency.⁶⁶

The Annual Representatives' Meeting 1922

Given the trepidation which had gripped certain elements of the CEC since the representative body's drive to make resolution 48 official BMA policy, the annual representatives' meeting in Glasgow, 1922 was a relatively painless affair. The annual report of council had already softened-up members by setting-out why the general position advocated by minute 48 was unjustified and giving indication of the circumstances in which the BMA would be willing to give support.⁶⁷ Prior to the annual representatives' meeting the CEC requested that the council withdraw paragraph 110 of their report.⁶⁸ This paragraph set out the four criteria that the professional secrecy committee had agreed would need to be satisfied before a member could claim BMA support, the last of which had demonstrated a shift from consideration of the consequences of doctors' actions back to an emphasis on duty. As Langdon-Down's proposed amendment during the Glasgow meeting was to show, the CEC were worried that an emphasis on doctors' duty of confidentiality, with no thought of the consequences, may stir memories of Elliot's ordeal and push the BMA back towards indiscriminate confrontation with the law. The council seem to have heeded the request, as paragraph 110 was not discussed. Rather, two proposals based on the professional secrecy committee's resolutions were brought before the representative body. The first was intended to quash the controversial resolutions of the previous year. It stated:

That Minute 48 of the ARM 1921 be rescinded, and that it be the policy of the Association to support in every way possible any member of the BMA within the UK who, in the opinion of the Council or the Central Ethical Committee acting on behalf of Council, after due consideration of the circumstances is

⁶⁶ BMA Correspondence, Cox to Hempson 6 April 1922.

⁶⁷ *BMJ* supp. 1922 vol. 1, p.134.

⁶⁸ BMA CEC minutes 30 May 1922.

deemed to have been justified in refusing to disclose any information he may have obtained in the exercise of his professional duties.⁶⁹

Langdon-Down guided this through without amendment.⁷⁰ Having reined-in the difficulties of the previous year, the second Council resolution aimed to guide the RB into a more moderate agenda for change:

That the Annual Representatives Meeting 1922, express the opinion that the proper preservation of professional secrecy necessitates a measure of special consideration being recognised for medical witnesses in courts of law above and beyond what is accorded to the ordinary witness.⁷¹

This proposal caused more of a stir. Buttar suggested that it was essential that information should not be given without the consent of the patient.⁷² Fothergill coupled this onto the Council's original motion and the representative body agreed it.⁷³ On putting this hybrid forward as the substantive motion, two amendments were proposed. The first suggested the omission of: 'without the consent of the patient concerned.' Clearly there were some who still believed in the *profession's* right to refuse. The amendment was lost.⁷⁴ No doubt concerned that the motion was heading towards too rigid a position, Langdon-Down proposed the insertion of: 'save to prevent grave injury or injustice to the state, the patient, or other members of the community.'⁷⁵ This amendment was also rejected and Fothergill's hybrid adopted.⁷⁶

The BMA's new position was that doctors required a special degree of privilege in court and patient consent to disclosure was essential. Bearing in mind Cox's view of the impossibility of developing watertight rules, CEC hearts might have sagged with the realization they would be given the task of detailing what the 'special degree of privilege' should be. The injunction that no information should be given without patient consent was too rigid without Langdon-Down's amendment.

⁶⁹ BMA ARM 1922 minute 60.

⁷⁰ Though there were seven dissentients. BMA ARM 1922 Minute 62.

⁷¹ BMA ARM 1922 minute 63.

⁷² Ibid. minute 64.

⁷³ Ibid. minute 65.

⁷⁴ Proposed by A Blackhall-Morison member for Marylebone. Ibid. minute 66.

⁷⁵ Ibid. minute 67.

⁷⁶ Ibid. minute 68.

Yet the representative body was not finished. They rejected a proposal to press for a government committee enquiry into medical secrecy, but resolved that an appropriate BMA committee should examine a proposed scheme for the modified notification of VD.⁷⁷ Thus, the 1922 annual representatives' meeting, in addition to rescinding resolution 48, had delivered more or less the council's agenda. The BMA were neither supporting the road to courtroom martyrdom advocated by the representative body in Newcastle, 1921, nor were they opting for Langdon-Down's vision of a better advertised *status quo*. Rather, they were somewhere in the middle with a notion that doctors should have privilege not to disclose without patient consent.

Away from the debates over medical privilege, there was little change in the CEC's staunch defence of medical confidentiality outside the courtroom. When a still-born child was found parcelled up and left on the banks of the river Wensum in Norwich, the city police wrote to doctors in the area requesting that they notify the police if approached by a woman showing signs of having recently given birth. On learning of this, the CEC were quick to resolve that the police should be informed that BMA members were advised to ignore the request and should 'in no circumstances' give the information asked for.⁷⁸ Whatever their position in relation to medical privilege, doctors were not to be used as detectives. By autumn 1922, the BMA council had established that the CEC were willing to consider applications for non-disclosure in court by members and advise whether the BMA would support their claim.⁷⁹ The CEC were also asked to ascertain the views of the legal profession and the Royal College of Physicians and Royal College of Surgeons.⁸⁰ Everything seemed to be heading towards a concerted effort to shore-up the boundaries of medical confidentiality against legal encroachment. Four months later the whole question had been shelved.

Moved to inertia by a man named Smith. The British Medical Association put privilege on long-term hold.

Several factors contributed to this change. The annual representatives' meeting, 1922 had resolved that a committee should consider the proposals for a modified form of

⁷⁷ The first proposal by C W Cunningham member for Hampstead; the second by Bishop Harman. BMA ARM 1922, Minutes 69 and 73 respectively.

⁷⁸ BMA CEC SSC Minutes, 10 July 1922.

⁷⁹ BMA CEC SSC Minutes, 31 October 1922.

⁸⁰ BMA CEC SSC Minutes, 14 November 1922.

notification of VD. In September an *ad hoc* committee was formed.⁸¹ The core problem to be addressed was that patients attending the VD clinics were not finishing their course of treatment. In 1920 only 20,000 out of 162,000 patients had continued treatment until cured or in a non-infectious state.⁸² Seeing this as a waste of state money, it was being suggested that all people who sought free treatment should be compelled to complete the course under pain of notification to the local health authority 'who would have power to warn him, and if still recalcitrant, take proceedings to ensure the completion of his treatment.'⁸³

The committee were not in favour of notification but decided to obtain the views of BMA divisions through a postal questionnaire. The results were overwhelmingly against notification. There was a unanimous rejection of the suggestion of general notification by name and address of cases of VD. The medical officer in charge of the VD clinic in Leicester and Rutland suggested that such a policy would close the clinic as no-one would attend.⁸⁴ There were traces of support for modified notification if patients stopped treatment early – 17 divisions were in favour as opposed to 51 against. However, a five year survey in Australia had shown that modified notification had failed to affect attendance rates at clinics. By July 1923, the committee had little difficulty in advising the council that any form of notification of VD was not a favourable option at that time. Yet, consideration of modified notification itself must have been a brake on the drive for privilege. Doctors would do well to justify keeping evidence relating to VD from the courts if they were able to break patient secrecy outside the courtroom.

In the meantime the CEC, having consulted with Dawson, were having problems following the council's instruction to open negotiations on privilege with the legal profession. Their main concern was the level of opposition they were likely to face from the judiciary. As the 1915 debate had shown, the BMA were not averse to fighting their corner against unsympathetic legal minds. This time, however, they were up against Lord Chancellor Birkenhead. In autumn 1921, Birkenhead had written an essay on medical secrecy which he circulated to all judges and Lords of Appeal. Designed to provide a definitive argument against the granting of medical

⁸¹ The committee consisted of the Officers of the Association, together with Drs H G Dain, E R Fothergill, T W H Garstang, Mr N Bishop Harman, R Langdon-Down, J McGregor-Robertson, E B Turner and Sir Jenner Verrall. BMA Special Committee on the Notification of VD 1922-23.

⁸² BMA Spec. Comm. VD, Turner memo, 19 September 1922.

⁸³ Ibid.

⁸⁴ BMA Spec. Comm. VD, 11 January 1923.

privilege, its impact filtered beyond legal circles and it was published under the title 'Should a Doctor Tell?' in a collection of essays in 1922.⁸⁵ Clearly flustered by its contents, the CEC stated the essay was 'an indication of the opposition which the medical profession may be likely to encounter in its plea for such special consideration.'⁸⁶ They recommended to the BMA council that in light of Birkenhead's views the best way forward would be to consult with the Royal College of Physicians and the Royal College of Surgeons in order to develop a consensus of medical opinion before approaching the law. However, when the council met to discuss this proposal in early 1923 they decided to recommend that no further action be taken for six months. No explicit reason is given and it can only be assumed that the council shared the CEC's concerns over Birkenhead's rallying of the judiciary. Council's inaction on the matter was extended indefinitely in September, and by 1924 their resignation was evident: 'the Council has come to the conclusion that no useful purpose would be served by proceeding further with it at present.'⁸⁷ The wilting drive for special consideration had retreated past the Rubicon.

⁸⁵ F E Smith, 'Should a doctor tell?', in *Points of view*, (London, 1922), 33-76.

⁸⁶ BMA Council agenda 14 February 1923.

⁸⁷ BMA CEC Minutes 25 September 1923 and BMA Council Annual Report 1923/1924.

Chapter 6 – The Lord Chancellor

‘The very pernicious heresy about ‘medical privilege’ ’¹

The Lord Chancellor’s file on the position of medical witnesses in legal proceedings opens with the memorandum sent from Christopher Addison requesting

if he could be advised what steps could most suitably be taken to secure the end which is contemplated in the memorandum, namely, that such privilege should be extended to medical men in legal proceedings as will secure absolute secrecy for persons who attend venereal disease clinics.²

Taking action on this, on 14 June 1920, Birkenhead wrote to the Lord Chief Justice (Lord Reading), the Master of Rolls, and the President of the Probate Divorce and Admiralty Division (Henry Duke), in order to gain their views on the issue. It was Duke who was the first, and as it turned out the only one, to respond. He saw Addison’s correspondence as raising two main questions.³ Firstly, a form of privilege should be extended to doctors on grounds of equality of treatment of learned professions. Secondly, that communications between doctors and patients with regard to the treatment of VD should be protected from disclosure, even in court.

To the first of these arguments Duke was at pains to point out that the privilege which prevented lawyers from disclosing information about their clients was in fact the clients’ privilege and not the lawyers’. The complexity of legal procedure meant that justice required that individuals caught up in legal proceedings needed access to those who had expert knowledge of the law in order to receive a fair trial. Therefore, claims for medical privilege based on equality of learned professions were misplaced. Moreover, there were rigorous restrictions upon the legal privilege which prevented its use to the detriment of the public interest. With regard to medical evidence relating to the treatment of a patient with VD, again Duke saw no reason for an exception to be made. If the law compelled diseased individuals to confide in a doctor then such involuntary confidences should not be voluntarily disclosed.

¹ PRO LCO 2/624 “Medical witnesses in legal proceedings: as to position of.” Phrase used by Duke in correspondence with Birkenhead 22 October 1921.

² LCO 2/624 Barter to Schuster, 3 June 1920.

³ LCO 2/624 Duke to Birkenhead, 3 July 1920.

However, voluntary communications to a doctor, in keeping with all other communications, save those which sought to obtain legal advice in relation to proceedings, should be available to litigants in a dispute.

Perhaps unsurprisingly, Duke's letter to Birkenhead dealt with Addison's request purely from a legal point of view. The language he used focused on compulsion and voluntariness in a legal sense only. The law might not compel someone suffering from VD to confide in a medical practitioner but the ill-effects of the disease could arguably leave an individual with little choice. When set within the context of highly publicised government VD treatment schemes which guaranteed confidentiality, it is clear that pressure, from the government and self welfare, to seek treatment, leaves Duke's tight legal definition of voluntariness in somewhat murkier waters. In the same vein, his interpretation of the public interest was also limited to its relation to the law. His argument that the absence of secure access to legal advice could mean the denial of justice to individuals was accurate and well-rehearsed. However, it did not take account of the similar argument that to deny individuals suffering from a disease with the social stigma of VD from access to confidential treatment was not only potentially to deny them recovery of their health but to put other members of the public at risk. This was the reason that the Ministry of Health had confirmed the pledge of confidentiality governing the public VD treatment centres when it took over the scheme. In Duke's mind, the public interest was served when legal justice was rightly administered. But, for those concerned with health, on an individual and communal basis, the public also had a vested interest in not jeopardising the schemes set up to tackle the scourge of VD.

Considering the scale of the problem that was demanding the time and efforts of the BMA and Ministry of Health, it is noteworthy that there is very little to be found in Birkenhead's file on confidentiality between Duke's letter of early July 1920 and May the following year. A copy of the Public Health (Venereal Disease) Regulations of 1916 and a copy of the inter-departmental committee on insurance medical records report of 1920 are to be found amidst sporadic correspondence with the Ministry. It appears that Addison's frustration at the delay in Birkenhead's furnishing him with an adequate response to his original request was not wholly unfounded. When it finally came, Birkenhead's terse response indicated that the

whole question was a 'grave legal matter'⁴, a description which further emphasised the judiciary's examination of medical confidentiality purely in terms of the law. Part of the delay in the judiciary reaching a communal decision was caused by the change of Lord Chief Justice. Having replaced Lord Reading, Lawrence was sent a copy of Addison's original memo and a copy of Duke's thoughts and asked to furnish his own opinion on the medical privilege being sought. In keeping with his predecessor (who had never formally set down his views before leaving office), Lawrence broadly agreed with the views of Duke. His only major addition to the argument was to take issue with Addison's belief that doctors did not claim privilege in criminal proceedings, as he himself had been obliged to threaten doctors with committal for withholding evidence material to a criminal case. This is an interesting point since it echoes a recurring discontent amongst the law that medical practitioners could, and at least sometimes did, hinder their work. Medical privilege, even if initially only granted in certain classes of civil cases, could seep further through the system of courts, eroding as it went the law's ability to draw on such a rich source of evidence.

If the Lord Chancellor's office had been measured in its approach to medical privilege to this point, the announcement that Lord Dawson was about to initiate a debate of the matter in the House of Lords with the aim of getting it referred to a select committee, sparked them into action. On 8 July 1921, Schuster, Birkenhead's personal secretary, wrote to David Davies in the Lord Chief Justice's office requesting that he prepare a detailed brief which would shed light on the nature of the legal privilege and show how this differed from the proposed privilege for medical practitioners.⁵ On the same day, Schuster also wrote to Sir Archibald Bodkin in the Director of Public Prosecutions department asking whether, in light of Dawson's motion, he could supply Birkenhead with 'ammunition'.⁶ Davies replied the next day indicating that he would create a file on medical privilege. Bodkins' reply, complete with a file of relevant ammunition, arrived two days later.

In collecting information for the forthcoming debate, the Lord Chancellor's office came across a speech made by Hempson, the solicitor to the BMA, which drew comparison between the position of the doctor and that of a priest. While it was acknowledged that a priest's obligation of confidentiality was absolute, Hempson had

⁴ PRO LCO 2/624 Birkenhead's reply to Addison's letter of 14 February 1921.

⁵ LCO 2/624 Schuster to Davies 8 July 1921.

⁶ LCO 2/624 Schuster to Bodkin 8 July 1921.

expressed the view that the doctor's obligation depended to a large extent upon his own personal relations and inclination. However, from a legal point of view, if Hempson believed there were times when a doctor, as a citizen or friend, may feel it necessary to disclose a patient's condition then:

the claim of privilege must fall to the ground, and...the obligation of secrecy really meant no more than an honourable understanding that a doctor would not gossip about his patient's affairs.⁷

Many members of the medical profession certainly saw the question of medical confidentiality in terms of honour. Langdon-Down, chairman of the CEC, realised as much when he stated 'the strong feeling that the doctors hold about this is just due to this, that it hurts the deepest feelings of decent honourable men that they should divulge information received under such circumstances.'⁸ Alfred Cox, medical secretary to the BMA, also came to express a very similar view: 'it is quite hopeless to try to build up a series of rules and regulations and to try to make it look watertight. The attitude rests on sentiment and tradition and it is no good trying to invest it with logical consistency.'⁹ Yet, the BMA did not meet with the Lord Chancellor. While the BMA and the Ministry of Health met to discuss medical confidentiality, and the Ministry corresponded with the Lord Chancellor's office, the three bodies never met together. Thus, three different interest groups each had multiple persons of profile expressing opinions on particular areas of a complex issue, with little co-ordinated debate. Then again, as the Lord Chancellor's file indicated, the BMA's conference with the Lord Chief Justice in 1915 had not led to a very satisfactory result.

With Dawson's proposed motion on their minds, the Lord Chancellor's office set about examining the law relating to the production of medical information in legal proceedings.¹⁰ They found a clear distinction between the production of medical evidence in serious criminal cases and other cases. In the latter set of cases, no medical information was to be made available, save the name and address of a medical officer who could give evidence if subpoenaed. Medical reports were not, in themselves, evidence and only became so if there was a meaningful discrepancy

⁷ LCO 2/624 Davies To Schuster 11 July 1921.

⁸ BMA CEC minutes 5 December 1921.

⁹ BMA Correspondence, Cox to Hempson 6 April 1922.

¹⁰ LCO 2/624 Document entitled 38/Gen No./946 Disclosures and production of records.

between what a medical officer had written in a medical report and the testimony which he subsequently gave in court. If both sides in a case consented, a medical report could be read as evidence in order to save the time and expense of compelling its writer to appear in court. A medical officer should not give any information except on subpoena and, even then, he could plead professional privilege although 'this will probably be overruled by the court.'¹¹ It is not clear when these guidelines were written, but, as the BMA and Ministry of Health were only too well aware, the previous 18 months had firmly underlined this last point.

In serious criminal cases all ordinary restrictions could be waived, with both the defence and the Director of Public Prosecutions having access to all information including medical records. The court itself could request to see such documents even if the defence had not asked for them. In cases where the Director of Public Prosecutions, or the police acting on his behalf, requested medical documents on the understanding that they would not be produced in court, this was deemed permissible. However, the Director of Public Prosecutions could use general information such as the fact that an individual had been in hospital or been treated by a doctor or had suffered a particular disease 'unless this is of such a nature as a patient might reasonably wish not to be disclosed.'¹² Who determined which diseases fell into the category of reasonable objection was not indicated. Police enquiries made without the authority of the Director of Public Prosecutions and enquiries by private prosecutors were to be treated in the same way as other cases falling outside the serious criminal case category. There should be no disclosure of medical records but, if possible, the name and address of a medical officer who could provide relevant comment would be made available.

Broadly speaking then, a distinction was drawn between the law's demand on medical information in serious criminal cases and other forms of judicial or police investigation. In the former, the courts could demand all forms of medical information including medical records while, in the latter, a medical officer could be subpoenaed to appear before a court to give testimony. No explicit criteria for categorising cases is presented, so presumably it was the law which decided if a criminal case fell into the category which allowed the court unrestricted access to medical information. This is an important point for one of the judiciary's main objections to the proposal of

¹¹ Ibid.

¹² Ibid.

medical privilege was the power it gave individual doctors to determine when they would give medical information. This, the legal authorities argued, hindered the interests of justice and could lead to inconsistency in practice. While some cases would be easily classified in the category of serious crime, others would, perhaps, rely far more on judicial discretion. Similarly, the power to determine when a patient's desire not to have details of his or her illness disclosed was 'reasonable', seems to leave the law in a similar position *vis-à-vis* individual and public health as the medical practitioners would be in relation to justice if medical privilege were allowed. The legal authorities would permit the law an amount of discretion with regard to matters of health in connection with justice, but they would not countenance medical practitioners having a level of discretion in matters of justice connected with health. No doubt, status played an important role in this distinction. Judges were official public servants while doctors, although increasingly involved with the state, were still private sellers of medical expertise. Private interest could cloud the doctor's vision and skew judgement on the admissibility of medical evidence.

It is natural that the judiciary would regard the interests of justice as paramount, but, as thinking individuals, they must also have been aware of the potential damage to the public health effort which would be caused by the highly publicised breaches of medical confidentiality during the enforced court appearances of doctors from the government's VD treatment scheme. A further explanation for their reluctance to consider medical privilege was the perception that, even without medical privilege, doctors had a tendency to stifle the ends of justice rather than betray a patient's confidence. The judiciary were, clearly, still suffering from the hangover of the 1915 debate. Birkenhead's file contains Avory's charge to the grand jury from the trial of Annie Hodgkiss in 1914 which had sparked the confrontation with the BMA. It had culminated with the Lord Chief Justice's failed attempt to impose on the medical profession their overriding duty to aid the law in the administration of justice, even if that meant contravening patient confidentiality. Lawrence, the new Lord Chief Justice, had recounted his experience of doctors attempting to claim medical privilege as witnesses in criminal trials. In preparing for Lord Dawson's debate, Birkenhead wrote to the Metropolitan Police Office at New Scotland Yard, requesting details of cases

in which there either has been, or may have been, a failure of justice due to the refusal of doctors to communicate with the police when they become aware that an illegal operation has been performed.¹³

If Birkenhead was going to defend the law against medical privilege then he needed hard evidence that legal thought against medical practitioners withholding information was well founded. The case of Annie Hodgkiss was one well-known and controversial example but the Metropolitan Police were being asked to provide a series of cases to show that the problem was a recurring one. Trevor Bigham of New Scotland Yard was only too willing to comply. Sending details of five cases from 1913-1919, Bigham added

I could, I have no doubt, give you many further cases if you desired, but I think these are quite sufficient to satisfy you as to the general line taken by the medical profession and as to the practical difficulties the police have to contend with in consequence.¹⁴

Doctors were too often an obstacle in the administration of justice. In the past, their short-coming had been their failure to notify the police in cases of criminal abortion before the mother died, a point which had been discussed at length in 1915 and was reiterated by Bigham in his letter. To extend a form of privilege to doctors that allowed them to withhold medical testimony once a case had reached court would exacerbate the law's problem. Rather than allowing doctors greater leeway, Bigham followed Lord Chief Justice Reading's line of thought from 1915 and advocated greater emphasis being put on the medical practitioner's duty to assist the authorities.

It seems as though one of the major difficulties in addressing the question of medical privilege was that, at times, the various sides were talking past each other. The Ministry of Health's priority lay with the potential detriment which a lack of medical privilege was causing to the effectiveness of their VD treatment scheme, and, thereby, public health. They were, therefore, only seeking privilege for doctors in civil cases. The Lord Chancellor, backed by other members of the judiciary and police, was concerned ~~with~~ preventing doctors becoming more of a hindrance to the criminal

¹³ LCO 2/624 Bigham to Schuster 13 June 1921.

¹⁴ Ibid.

justice system. Meanwhile, the BMA were in turmoil with the council and CEC engaged in a game of tug-of-war with the representative body over the use of BMA resources to challenge the law on medical privilege. There were pockets of interaction on the issues. Bodkin wrote to Schuster to inform him that he, along with Blackwell of the Home Office and Newman from the Ministry of Health had, two weeks prior, had a long meeting to discuss the attitude of VD clinics to the use of their information in legal cases.¹⁵ This, along with McCardie (*Garner v Garner*) and Horridge's (*Needham v Needham*) pronouncements on confidentiality in the divorce courts, and a leader in the *Times*, Bodkin offered to send to the Lord Chancellor. In an aside, Bodkin qualified his suggestion that the documents he is sending might tire Birkenhead, by stating 'but it seems quite impossible that the Lord Chancellor can ever get weary!' Seemingly, the unhurried approach which had so infuriated Addison back in early 1920 had been replaced with a great sense of urgency as Birkenhead gathered the pieces from which he would assemble his case for the debate on 27 July. As Schuster observed: 'The Chancellor attaches great importance to the question and to this particular occasion and wishes to deliver an important and conclusive speech.'¹⁶

A letter from the Home Office to the Lord Chancellor indicated that the memo which Bodkin had prepared subsequent to the meeting between the Home Office and the Ministry of Health, had not gone down well with the latter.¹⁷ It appeared that the Home Office had felt that general agreement had been reached that it would be 'convenient' and 'reasonable' for a doctor to give a statement to the police in all cases where they had medical information about an individual. The Ministry of Health denied assenting to such a proposal. In their view, a doctor should inform the police of information which would exonerate an accused individual, but in all other cases it should be left to the doctor's discretion to supply voluntarily information to the police.

With the Ministry of Health and the Home Office finding it difficult to reach agreement, Alfred Mond wrote to Birkenhead six days before Dawson's motion was due for discussion.¹⁸ Having read Addison's correspondence with Birkenhead, Mond was keen for a meeting to agree a cabinet line on the question. He indicated that he

¹⁵ LCO 2/624 Bodkin to Schuster 11 July 1921.

¹⁶ LCO 2/624 Schuster to Blackwell 18 July 1921.

¹⁷ LCO 2/624 Blackwell to Schuster 15 July 1921.

¹⁸ LCO 2/624 Mond to Birkenhead 21 July 1921.

was under considerable pressure from doctors and that he had come to the conclusion that there was a very strong case for a medical privilege, akin to that of lawyers, in civil cases only. This, he suggested, would be 'only fair' to doctors and in keeping with several 'respectable precedents both abroad and in our self-governing dominions.' It would also be essential to the interests of the Ministry's VD policy

the essential foundation of which is the secrecy of the transactions. If we cannot secure such secrecy to the doctors in civil proceedings, I anticipate something approaching to a crisis.¹⁹

In order to avoid Dawson's request for an investigation of medical privilege by a select committee, Mond proposed the passing of a short bill along the lines of the statutory medical privilege in New Zealand (a copy of which Mond sent to Birkenhead), but only applicable to civil cases. If Birkenhead was in agreement then Mond would explain the situation to Dawson, otherwise a meeting the following week would be in order.

In stark contrast to the treatment his predecessor had received from Birkenhead, Mond received a reply from the Lord Chancellor's office the following day.²⁰ Apologising for not being able to write in person, Birkenhead welcomed Mond's stance against a medical privilege in criminal cases. However, he made clear that he was not wholly convinced of the Ministry's intentions:

There has lately been a considerable disposition to obstruct criminal investigations in this way [claiming medical privilege], and...some of the communications made by the Ministry of Health to doctors in the country and to the Public Prosecutor and the Home Office have lent colour to the idea that the Ministry took a different view [to that now expressed by Mond].²¹

Birkenhead would respond to Dawson's motion that there would be 'no possibility that doctors can in criminal proceedings be allowed to escape from the ordinary

¹⁹ Ibid.

²⁰ LCO 2'624 Schuster to Mond 22 July 1921.

²¹ Ibid.

obligations of citizenship.’²² Clearly, the Lord Chancellor had a very negative view of the motives and potential outcome of any medical privilege which had effect in criminal cases. As for civil cases, Birkenhead expressed his awareness of the excellent work the VD clinics were doing and the ‘national importance which must be attached to their labours.’²³ Despite this he found himself ‘reluctantly unable to acquiesce’²⁴ with Mond’s proposal for a bill based on the New Zealand Evidence Act. His objection focussed on the distinction between a doctor’s behaviour when giving testimony in a civil case and their obligation outside the courtroom. Drawing on Hempson’s speech to the BMA twelve months prior, Birkenhead noted Hempson’s belief that circumstances could leave a doctor in a position where, as citizen or friend, he felt it necessary to disclose information which had been gained in a professional capacity.²⁵ Hempson’s example of the syphilitic fiancé produced a dichotomous response from the representative body at the BMA annual representative meeting in 1920. This, in Birkenhead’s view, was evidence enough that public opinion would not support legislation which forbade disclosure of medical information within the context of a civil court case, but left disclosure outside the courtroom to the discretion of the individual doctor on a day to day basis. To emphasise the unanimity of legal thought on the matter Birkenhead cited the concurrence of his views with those of the previous Lord Chief Justice (Reading), the current Lord Chief Justice (Lawrence), the Master of the Rolls, the President of the Probate Divorce and Admiralty Division (Duke), and probably all of the high court judges.

However, although the judiciary was more unified in its opinion on medical confidentiality than the BMA representative body that had heard Hempson’s speech, there was an awareness that showing up inconsistencies in medical opinion would not be sufficient justification for opposing a select committee inquiry into the possibility of legislation on medical privilege. Certainly, they were primed with examples in which doctors’ reticence to provide the law with information had obstructed the ends of justice, but, by Birkenhead’s own admission, the prevalence of VD and the importance of secrecy to the efficacy of treatment programmes, made medical confidentiality key to another public interest: the nation’s health. The sanctity of the doctor-patient relationship was a foundation stone in the medical profession’s belief

²² Ibid.

²³ Ibid.

²⁴ Ibid.

²⁵ *BMJ* 3 July 1920. Supplement pg.10.

system, and one which had already been shaken by government measures on notification and public health in the late nineteenth and early twentieth centuries. As medical officers working in the VD clinics had made clear, government guarantees that doctor – patient confidentiality would be central to their work, were having their limitations highlighted in very public circumstances. If the law was to further undermine confidentiality by rejecting medical privilege even in cases where the information was received under the rules of secrecy for VD clinics issued by government, it had to do so in such a way as not to push the medical officers at the clinics into fulfilling their threat of resignation.

In a letter to Schuster, Bodkin suggested that the argument for privilege on the basis of the sanctity of the doctor-patient relationship could be undermined by drawing an analogy with another group of cases.²⁶ Under common law, a husband or wife was forbidden from giving evidence against their spouse because of the law's regard for the confidences between husband and wife. By section one of the Criminal Evidence Act, 1898 (section 1, proviso D) this rule was formalised in statute. However in both forms of the law, exceptions were made in instances of criminal activity i.e. violence on a spouse, or incest. Bodkin suggested that if the confidentiality that existed in the more intimate relationship of a husband and wife was subject to limitations under criminal law, then there was less reason to insist that the doctor - patient relationship should be privileged. Certainly, this went some way to undermining the central argument of doctors with regard to the special nature of their relationship with clients, even in the sensitive context of VD treatment clinics. But by Bodkin's own admission, the analogy was for exceptions in criminal cases alone.

Davies, having acted on Birkenhead's request to examine the proposals for medical privilege and provide him with arguments as to how it differed from the established privilege of lawyers, produced a lengthy note on the subject. Citing many cases, he paid particular attention to the statement given by Lord Chancellor Brougham in the case of *Greenough v Gaskell*, 1833. He quoted at length Brougham's assertion that:

²⁶ LCO 2/624 Bodkin to Schuster 21 July 1921.

The foundation of the privilege is 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 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.²⁷

Brougham's words, given amidst a case which revolved around the question of legal privilege, seem to fit perfectly with the line of thought advocated by Birkenhead. 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 of the *Greenough v Gaskell* case, reveals that Davies had been somewhat liberal with the truth in trying to manufacture a continuity in legal opinion from the 1830s through to the 1920s. Without giving any indication that he had edited Brougham's statement, Davies removed the last section of Brougham's first sentence. In fact, 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.²⁸

Clearly, the re-integration of these words into Brougham's statement gives an altogether different complexion to his thoughts, than the statement presented by Davies. For a start, consensus on privilege between Brougham and Birkenhead only extended to the legal variety. On medical privilege, the more important issue for Birkenhead and Davies, the two Lord Chancellors had conflicting ideas, so Davies simply dropped that section of Brougham's statement. Considering that the judiciary's argument against medical privilege was rooted in the need for all relevant information to be made available to the law, it was more than a touch hypocritical for a member of the Lord Chief Justice's office to omit highly relevant information from the position

²⁷ LCO 2/624 Davies to LC. No date given.

²⁸ Brougham in *Greenough v Gaskell* (17& 31 Jan 1833). 1MY & K 98.

of a past Lord Chancellor on the question of privilege, because it did not suit the argument which the legal authorities wished to make in the 1920s.

As previously noted, Lord Dawson did not raise the question of medical secrecy in the House of Lords. In a printed memo, Birkenhead indicated that, at a cabinet meeting on 25 July, where the Ministry raised the question of Dawson's motion, it was agreed that 'no time would be available for the discussion of the question before the 27th', so Dawson would be asked to postpone it.²⁹ Obviously, the cabinet wanted to discuss the matter in detail and reach some form of consensus before a general discussion in the House of Lords, but the established differences between the Ministry of Health and the Lord Chancellor would not make for a short discussion. However, Dawson, in complying with the cabinet's wishes, indicated that he would seek to raise the motion again in the near future. Pre-empting any widespread debate on confidentiality, before the cabinet could have the chance to discuss the question at length, Birkenhead sent a copy of his views on the question to cabinet members. He indicated that there was no disagreement between Mond and himself on the question of medical privilege with regard to criminal cases: neither supported a privilege. In other circumstances, however, there was greater division. Birkenhead was at pains to point out the unanimity of legal opinion against the granting of any form of medical privilege, suggesting that, once cabinet had assessed the merits of the legal and medical views, it could announce a decision on the matter. Mond, clearly, did not wish to rule out the possibility of a select committee looking into medical privilege 'in view of the strength of medical feeling on this subject'³⁰. The Ministry of Health was, by this stage, proposing that legislation on medical confidentiality should be along the lines of 'A physician etc. shall not without the consent of his patient be compellable to divulge in any civil proceeding, etc.' For Birkenhead this was proof that the privilege that was being sought was in fact the doctor's privilege to decide when he gave evidence. This being the case, all comparisons with legal privilege were forfeit, for, as the law had pointed out at length, legal privilege was the privilege of the *client* not the lawyer. A medical privilege of the nature suggested by the Ministry of Health would give doctors the powers to protect or injure their patients' cases during hearings in court, based solely on their own judgement. Such a proposal was without precedent. Moreover, the Lord

²⁹ LCO 2/624 Birkenhead memo 28 July 1921.

³⁰ LCO 2/624 Mond to Birkenhead 2 August 1921.

Chancellor's office understood that doctors wanted a privilege which covered them in civil and criminal proceedings, so, even if the Ministry of Health's proposal was agreed to, there was no indication that the medical profession would be content.

Even though Dawson's motion was edged off the table by the more legally minded members of cabinet, Birkenhead continued to be occupied with the medical profession's claims for privilege. Letters still came in presenting more examples of medical incompetence obstructing the ends of justice, clarifying points of law on legal privilege and drawing analogy with the law's attitude to the confidentiality of information given to clergymen.³¹ October 1921 was a particularly busy month in which Birkenhead's memorandum entitled 'Should a Doctor Tell?' was printed and copies circulated to all judges and Lords of Appeal. In it, Birkenhead collected together the morsels from which he had intended to produce his all important speech in response to Dawson. He noted that an exacerbation of the problem of medical confidentiality was caused by the lack of clarity about what the medical profession were actually seeking, their claims and practice being 'discordant and loose.'³² He dealt with the proposed analogy with legal privilege, incorporating unchanged, Davies' inaccurate version of Brougham's statement in *Greenough v Gaskell*. In ignorance of his misrepresentation of fact, Birkenhead went on to state 'since the Duchess of Kingston's case it has never seriously been questioned that the law is as it was then stated to be by Lord Mansfield'.³³ He further noted the statutory obligation on doctors to breach confidentiality imposed by the Infectious Disease (Notification) Act 1889 and the Notification of Births Acts of 1909 and 1915. Yet, unlike the impression which the Lord Chief Justice (Reading) had conveyed to the BMA in 1915, Birkenhead was clear that the doctor was not to act as spy or detective.³⁴ Nonetheless, in keeping with the impression, conveyed to him by judiciary and police alike, that, too often, medical men impeded the law through lack of co-operation, Birkenhead was keen to stress the doctor's role in aiding the cause of justice. On the question of the notification of criminal abortion he went so far as to state 'the attitude adopted by doctors in some of these cases almost makes one regret that the offence of

³¹ LCO 2/624 Bodkin to Schuster 27 July 1921; Davies to Schuster 4 August 1921; Davies to Schuster 10 October 1921; LCO 2/624 Schuster to Roche 29 June 1922

³² Ibid. 43

³³ Ibid. 47

³⁴ Ibid. 49

“misprision of felony” has been allowed to become obsolete.’³⁵ Such a statement provides a sharp contrast to the opinions expressed by Avory and Clarke during their consultation with the RCP in 1895. However, Birkenhead was aware that the key issue aggravating the early interwar debate was VD. He portrayed the reasonableness of the law’s demands on doctors by using emotive examples involving the abuse of women and children, and employing evocative phrases such as

the quarrel here, if there be a quarrel, is not between the law, on the one hand, and the medical profession on the other. It is between those who claim this privilege, and the parents of little children whose protection is the primary aim of the law.³⁶

In his effort to provoke sympathy in the reader for the parents of little children, Birkenhead appears to have overlooked the contradiction in his argument. If the primary aim of the law was the protection of little children and the medical profession were, in the law’s eyes at least, threatening to jeopardise that, then, evidently, the quarrel did exist and was, indubitably, between the law and the medical profession. In such points, Birkenhead seemed more concerned with inciting the support of public opinion than giving an accurate account of the debate. Nonetheless, he claimed to recognise the importance of medical confidentiality, particularly with regard to the national problem of VD and the fact that ‘the complexities of life in a civilised community such as our own produce a web of confidential relations and confidential communications round every citizen.’³⁷ However, even in situations where confidentiality was central to a relationship – be it in connection with an individual’s finances at a bank, or, (drawing on the example he’d been furnished with by Bodkins), in the intimate relationship of a husband and wife – there were always exceptions to the rule.³⁸ Save for the growing privilege of lawyers, the tendency had been towards greater openness of testimony in court, and Birkenhead, backed by ‘most men of experience in every branch of the law’³⁹ felt it would be a retrograde step to create an unprecedented level of privilege for doctors or, indeed, nurses and

³⁵ Ibid. 55

³⁶ Ibid. 62

³⁷ Ibid. 72

³⁸ Ibid. 73

³⁹ Ibid. 75/6

midwives, for Birkenhead could not see why medical privilege would not extend to them.⁴⁰

It seems that, in legal quarters at least, Birkenhead's essay was very well received. The Lord Chief Justice sent word that, at the meeting of judges, Birkenhead's stance against medical privilege had met with their approval. Again the main reason appeared to have been the detrimental impact that such a privilege would have in impeding the ends of justice.⁴¹ While outwardly the question of medical privilege was being referred to by high legal figures as 'a subject of great and pressing importance'⁴², in their internal correspondence it did not receive such high praise. In complementing Birkenhead on his published memorandum, the President of the Probate, Divorce and Admiralty Division, Sir Henry Duke, wrote:

I am delighted to find that you have made time to explode the very pernicious heresy about "medical privilege" which has spread in a remarkable way in the last few years.⁴³

In the opinion of the judiciary and law officers of the crown, Birkenhead had used his legal 'ammunition' to good effect.

⁴⁰ Ibid. 70/1

⁴¹ LCO 2/624 LCJ to Birkenhead 13 October 1921.

⁴² LCO 2/624 Taken from printed note attached to 'Should a Doctor Tell?' memo printed for cabinet.

⁴³ LCO 2/624 Duke to Birkenhead 22 October 1921.

Chapter 7 – The Attempts to Pass Legislation

‘A game of snakes and ladders’¹ is how Roy Jenkins referred to the process of getting a private members’ bill passed into legislation. Each year a small group of MPs, whose names are drawn from an open ballot, get the opportunity to propose and promote legislation of their choice. Since 1867, the government has dominated the legislative agenda and private members’ bills have been limited to Fridays in the first twenty weeks of each parliamentary session. Success in the ballot allows an MP to give the bill its first reading in Parliament. This is a reading of the bill’s title only and there is no detailed debate – indeed often the specific terms have not been drafted by the time of the first reading. Having been announced, a date and time is set for its second reading. At the allocated time, if there are no objections to its being read a second time then the bill moves to be considered in detail by a committee who make recommendations about the bill’s merits to the House, which then votes to accept or reject the proposal. In order to become law, the bill must go through these three stages in both the House of Commons and the House of Lords, making it a lengthy process. If a bill fails to make it through the committee stage before the end of the parliamentary session it lapses along with all uncompleted legislation and must begin the process all over again when someone chooses to re-introduce it. In such a process the threat posed by the ‘snakes’, to which Jenkins referred, must be minimised. As another authority on the British system of government observed:

To get a bill enacted requires skill, patience, determination, a measure of support from more than one party, and the sympathy of the ministers most directly affected.²

While private members’ bills are not nearly as numerous as governmental ones, they do at times lead to the passing of important legislation.

Having previously examined the failed attempts to set a new common law precedent in the early interwar years, this chapter analyses two attempts to pass legislation conferring a level of privilege to doctors in court, the first in 1927, the second in 1936. Both were private members’ bills and both were put forward by

¹ A H Birch, *The British System of Government* 9th edition (London, 1993), 184.

² Ibid. 183.

Ernest Gordon Graham-Little. Born in Bengal and educated in South Africa where he took a B.A. in literature and philosophy at the University of the Cape of Good Hope, Graham-Little won a Porter scholarship to study medicine at London University. After graduating, he spent time in Dublin and Paris before specialising in dermatology. He was the Independent Member of Parliament for London University from 1924 until the abolition of the university franchise in 1950, and was knighted in 1931.³ In 1931 he also changed his surname by deed poll from Little to the hyphenated Graham-Little.⁴ While neither of his bills passed into law, they merit closer examination than they have hitherto received. Morrice mentions them in passing in his thesis, seeing them as nothing more than the re-working of old arguments.⁵ While much of the debate associated with the bill was similar to previous discussions, this is indicative of the ongoing tension surrounding the issue of medical confidentiality throughout the interwar years.

It would be easy to interpret the 1927 attempt at legislation as a direct re-run of the early interwar years. It was triggered by the same factor as the immediate post-war debate: a divorce hearing in which medical testimony was demanded on the existence of VD in one of the parties. Such cases were important factors both in terms of the issues they raised and, particularly, in the publicity and conspicuous debate which they generated. Nonetheless, they were part of a broader underlying unease that surrounded the conflicting viewpoints on the boundaries of medical confidentiality, which in turn reflected uncertainty in the relationship between the relative powers of the executive and the judiciary. As previously noted, it was Birkenhead's well-publicised and authoritative rhetoric, along with the consistency of his stance, which had worn-down the supporters of privilege in the early 1920s. Yet, there were many areas of medical practice which were too ill-defined to permit of the type of definitive approach which Birkenhead had advocated. The CEC had come to this conclusion when they were asked to consider guidelines for BMA members in 1920 and Lord Riddell took a similar line in an address to the Medico-Legal Society in June 1927.⁶ George Allardice Riddell was a talented lawyer who became legal adviser to the *News*

³ See entry for Ernest Gordon Graham-Little in *The Dictionary of National Biography* and *Who Was Who* vol.4 1941-50.

⁴ *The Times* 12 February 1931.

⁵ A Morrice, 'Honour and Interests': *medical ethics in Britain and the work of the British Medical Association's Central Ethical Committee, 1902-1939*, (University of London, MD Thesis, 1999), 279-280.

⁶ BMA CEC minutes 9 November 1920; for Riddell's address see *BMJ* 2 July 1927 p.17.

of the World. By 1903 he decided to move from law into journalism. Being on good terms with Lloyd George he was often used as liaison officer between the press and British delegations to major international conferences such as the Paris peace conference of 1919. Despite no longer practising law, Riddell maintained a keen interest in medical jurisprudence.

Riddell had been amongst the audience at Lord Dawson's controversial address on confidentiality to the Medico-Legal Society in 1922. In the prolonged discussion following that speech, Riddell disagreed with Dawson's belief in the sanctity of medical confidences, describing the latter's approach to confidences in civil cases as 'extraordinarily nebulous'.⁷ To the complex problems of VD doctors testifying in court, Riddell had offered a simple solution: doctors could be in the habit of forgetting certain information before official proceedings got underway, in which their evidence may be called: 'such a little lapse would not be visited with penalty on the day of judgement.'⁸ By 1927, Riddell was not so light-minded in his approach. The fact that the question was the subject of two high profile speeches and discussions in a short space of time, along with Riddell's change in position, testifies to the ongoing difficulties in clarifying the boundaries of medical confidentiality. The aim of the Medico-Legal Society was to discuss subjects of deep interest to lawyers, doctors and the public. In the opinion of some members, there was none as apt at fulfilling those criteria as medical confidentiality.⁹

While Riddell had become more sympathetic to the case for the sanctity of secrecy, his address, entitled 'The law and ethics of medical confidences', was by no means revolutionary in content. In general, the doctor's duty to society by aiding the law was clear in cases of crime (abortion continuing to prove a moot point). There were, however, other areas where conscience was still put forward as the guiding light that determined whether a doctor should pass on information to a third party. These were the areas which kept the question rumbling-on and the passage of time brought yet more examples to be added to the list of difficult scenarios. Riddell reeled-off the familiar problems regarding doctors' duties to tell when they were employed by someone other than the patient or in cases where there was the potential of grievous harm being caused to a third party – the syphilitic fiancé again amongst the list of

⁷ *BMJ* 25 March 1922, p.495.

⁸ *Ibid.*

⁹ Sir William Collins in *Lancet* 2 July 1927, p.14.

illustrations. More original was his querying of the ethics of selling doctors' case books containing information on their patients. A possible solution would be to insist on destroying such books when the doctor died but this 'might rob future generations of much interesting information'.¹⁰ Duty and consequence seemed at loggerheads again.

Aside from the dilemma over case books, Riddell's address essentially summarised the main themes of the debate from the early part of the twentieth century. Ivory's remarks in 1914 and their heated aftermath were re-examined; the comparison with legal and spiritual privileges and the laws of other countries were rehearsed; arguments over public interest and the relative merits of public health *vis-à-vis* justice were all touched upon; and the pecuniary interest and advertising elements were not overlooked. Martyrdom and the treatment of John Elliot of Chester came up in discussion and the report of the address ended with Sir William Willcox's view that the 'fair and proper attitude' for a doctor to adopt when called as a witness was to refuse to answer until ordered and then give evidence under protest i.e. the line advocated for nearly a decade by the Ministry of Health and the BMA. There were some indications that opinions on medical privilege were shifting as Riddell suggested that limited privilege was supported not just by medical men but by 'distinguished lawyers' – presumably, this held more weight than the support given by the *Solicitor's Journal* in 1920. On the whole, however, the impression conveyed was that the emphasis still lay on legal interests over medical.

As well as the report of Riddell's speech, the *Lancet* carried a leading article on professional secrecy in its early July edition.¹¹ It noted that the old and honourable tradition of medical secrecy 'does not fit comfortably into legal theory.'¹² This seems to sum up the problem that had been frustrating participants in the debate since at least the time of the Royal College of Physicians consultation with Ivory and Clarke: how to marry the interests of medical tradition and legal procedure. The continued tension in the 1920s suggested that the solution imposed by Birkenhead would not last. However, if the medical profession wanted to change the arrangement, it seemed that one essential ingredient was still missing: 'It is strange that the public has never insisted upon a change in the law and upon an absolute duty of medical secrecy in the

¹⁰ *BMJ* 2 July 1927, p.17.

¹¹ *Lancet* 2 July 1927, p23.

¹² *Ibid.*

law courts'.¹³ That the writer should have found the lack of public support strange, is itself intriguing. There had not been much cause for the public to make vocal protest. Most of the discussions on privilege had taken place in private meetings between representatives of the judiciary, government and medical profession and had been reported more in the professional journals than in the newspapers. Indeed, keeping it out of the press had been one of the criteria stipulated by the Lord Chief Justice in 1915. The one exception had been the coverage of the divorce cases – *Garner v Garner* and *Needham v Needham*. Yet even in those instances the coverage, though intense, had been short-lived. The general public was unlikely to be spurred into action by occasional cases involving doctors giving evidence about venereal disease in a divorce hearing which had little relevance to them. If 'the public' meant those who were faced by divorce proceedings from their spouse, who in turn was likely to cite VD as a principal ground for separation, then fear of guilt by association might well have discouraged the formation of a "Keep my VD secret" campaign. All in all, the general discussion of the boundaries of medical confidentiality took place outside the realms of the general public, and only spilled over in any significant sense in VD divorce cases. Important as the treatment of VD was, and significant as the rise in the number of divorce cases in the 1920s was also, medical privilege – widely acknowledged to be a complex balancing act - was hardly the sort of bandwagon that the general public would be waiting to jump on in large numbers.

If public support was not likely to provide a useful basis to challenge the status quo, the power of government directives would have to be used again as the principal weapon. A fortnight after the reports of his address, Riddell indicated that his attention had been drawn to the VD regulations issued by the Local Government Board in 1916.¹⁴ The terms of article II (2) had raised the possibility in Riddell's mind that statutory secrecy had been established in cases of doctors attending patients at the VD clinics. This was the argument that Elliot had made with little success in the *Needham v Needham* case and, in recounting it during the medico-legal society's discussion, Sir William Collins expressed his deep regret that Elliot had not gone further on the road to martyrdom.¹⁵ An article in the *Lancet*, focusing specifically on secrecy and the VD clinics, followed Riddell's new line of thought by suggesting that

¹³ Ibid.

¹⁴ *BMJ* 16 July 1927, p.116.

¹⁵ *BMJ* 2 July 1922, p.18.

the government regulations might override the judicial power to force medical disclosure, though it was unlikely that a judge would take this view.¹⁶ Citing the ruling in *Garner v Garner* which stated the regulations were not authority to exempt a VD medical officer from giving evidence in court, the *Lancet* suggested that doctors should strive to claim the utmost degree of privilege possible, stressing the importance of secrecy to the success of schemes to tackle VD. A week later, the same journal was reporting that a medical witness had responded to the call.

Anything you say will be taken down and used in evidence against you.¹⁷

Thus, within a month of Riddell's address to the Medico-Legal Society, the case which Graham-Little was to cite as the immediate trigger for his attempt at legislation, arose.¹⁸ As well as involving a VD clinician refusing to give evidence in a divorce hearing on grounds of medical privilege, the case had two other similarities with previously significant trials. Firstly, it was heard at the Birmingham Assizes – the same court from which Ivory had delivered his tirade against the medical profession's code of secrecy in the trial of Annie Hodgkiss in December 1914. More importantly, it was heard before Justice McCardie, the judge involved in the *Garner v Garner* case which had sparked the Ministry of Health into action in 1920. The *Solicitors Journal* at that time had suggested he should have had the courage to rule in favour of granting a measure of privilege to the doctor, but in the *1927 Birmingham Case* it was clear that McCardie's position remained unchanged.¹⁹ In the *Garner v Garner*, case the medical testimony on the presence of VD was sought by a patient who consented to the disclosure but, in the *1927 Birmingham Case*, a wife was seeking evidence of her husband's previous treatment for VD and had subpoenaed Dr Assinder, the medical head of the VD department at the Birmingham General Hospital. In the witness stand, Assinder explained that he had not treated the man in question in 1924, had not been head of department when the husband was alleged to have attended and that a number of doctors were engaged in the work at the clinic. Each doctor had his own papers which were personal property and could not be produced as evidence by the head of the department. Whilst recognising the reasoning

¹⁶ *Lancet* 16 Jul 1927, p.139.

¹⁷ The *Lancet's* pessimistic assessment of the VD doctor's position *vis-à-vis* patients after McCardie's ruling at Birmingham. *Lancet* 23 July 1927, p.178.

¹⁸ Although reported in *The Times*, the names of the parties involved in the case are not cited. The case will hereafter be referred to as the *1927 Birmingham Case*.

¹⁹ *Solicitors Journal* 24 January 1920.

behind this position, McCardie emphasised that the doctor could not claim privilege and if he refused to comply with the request for evidence he would be imprisoned for contempt of court. McCardie further threatened that if the doctor did not give evidence

every medical man and a number of officials from the hospitals would have to be called to the court, and ultimately the documents must be made available. If information were not given that should be given, and if documents were not produced which should be produced, the law...would be enforced.²⁰

With the profile of the medical privilege debate on the rise again, McCardie seemed keen to nip it in the bud. Not only were government departmental regulations of inferior authority to judicial powers, but any doctor who was contemplating taking Elliot's martyr approach would find himself in prison and his colleagues on the witness stand in his place. It is worth emphasising this point. If McCardie's antidote to medical martyrdom was to subpoena the rest of the hospital staff, the resultant disruption of services at the Birmingham General Hospital may well have produced the support from the general public which had, so far, been lacking. The judge may seem like the unreasonable party for disrupting medical provision in order to get at medical evidence – covered by a government pledge of secrecy – for use in a civil divorce suit. The Birmingham population would presumably be unhappy about a judge imprisoning the staff of the local hospital in such circumstances. Consequently it would be feasible that the precedent for medical privilege could be set.

However, McCardie could always bank on the converse being true. The public, which had thus far failed to show interest in the medical privilege cause, might react against the doctor, who, having been warned of the consequences of his failure to give evidence, still maintained silence – leading to the disruption at the hospital. McCardie, having addressed the question in the early 1920s, would be aware that the medical profession would have far more difficulty in making a persuasive case to change the status quo than the judiciary would have in defending it. In such a complex debate, the clear-cut ruling from the Duchess of Kingston's case would always give the law the upper hand.

²⁰ *Lancet* 23 July 1927, p.178.

After an adjournment of five days while further evidence was produced, the surgeon to the hospital, B.T. Rose, gave evidence under protest. It is noteworthy that while McCardie was clear that there was no medical privilege, he asked the counsel to the petitioner 'if he had considered the question whether or not a doctor was bound to disclose to the court information obtained by him when acting confidentially in the special treatment of a particular disease.'²¹ In other words, what weight should be put on the 1916 VD regulations that guaranteed secrecy to patients attending VD clinics? Counsel did not think the regulations equated to privilege in court, and, consistent with his own ruling in *Garner v Garner* and the line taken by Justice Horridge in *Needham v Needham*, McCardie agreed. The question that had been posed by Riddell and the medical journals, only two days prior, had already been answered. Regulations issued by a government department were clearly not sufficient to prevent the breach of confidence when evidence was required in court – even when the case was a civil divorce suit. The *BMJ* concluded: 'the only way in which the Ministry of Health can implement its promise of secrecy to patients attending venereal disease centres will be by direct legislation stating in clear terms that communications by patients are protected from disclosure in a court of law.'²² Perhaps Graham-Little, a regular contributor to the *BMJ*, read this. In any event, it was this legislation that his private members' bill hoped to provide.

In Mr Neville Chamberlain's hands the matter will not be allowed again to be forgotten.²³

Naturally, the crescendo of interest in confidentiality had not passed-by the Ministry of Health. Within days of McCardie's ruling, memoranda started circulating on the subject. Many of the civil servants at the Ministry had been engaged in the early interwar debate. Given their experience of the difficulties involved in the question, there was no repeat of Addison's enthusiastic move to the judiciary with a request that they grant privilege to doctors. On the contrary, there was a palpable uneasiness in the air, particularly amongst three experienced figures: Machlachlan, Robinson and Newman. Machlachlan sent a memo to the others on 21 July indicating that McCardie's ruling in the 1927 *Birmingham case* looked set to reopen the question.

²¹ *BMJ* Supplement, 23 July 1927, 55.

²² *Ibid.*

²³ *BMJ* 30 July 1927, p.179.

The Birmingham clinic was an important one and it was feared that the press coverage would deter patients. Moreover, just as the clinic advertisements, with their prominent pledge of secrecy, had been criticised in the aftermath of the early interwar rulings, VD doctors were again questioning their own position with regard to the guarantee of secrecy. The director of the Birmingham clinic who had originally been called before McCardie was reported to be saying that he would not issue any more pamphlets on which the government pledge of secrecy appeared. Having dissuaded Dawson from pursuing privilege in 1921, the Ministry would now have to return to a consideration of legislation. As Robinson put it: 'this is a most thorny subject and we must take it up where we left it in 1921.'²⁴ For the time being they would have to prepare to field parliamentary questions on it. All three were agreed that a general statement, indicating that the Ministry were aware of the *1927 Birmingham Case* and were giving it careful consideration, would suffice for the time being.

On 25 July, Dr Vernon Davies, Conservative MP for Royston, enquired in parliament if McCardie's ruling at Birmingham had come to the attention of the Minister of Health (Neville Chamberlain). Furthermore, he wanted to know whether Chamberlain would consider introducing legislation which allowed doctors to refuse to give evidence about confidential information 'at least in the case of this disease'.²⁵ Sir Kingsley Wood, parliamentary secretary to Chamberlain, following the advice given by Machlachlan's memo, stated that they were aware of the ruling and the difficulty of the questions involved and would give it careful consideration. They were still giving it consideration in November when Vernon Davies repeated his question.²⁶ Meanwhile, the medical journals provided a measure of the difficulty to which Wood referred. On the same day that Davies' question to the Ministry was reported, the *Lancet's* correspondence pages contained three letters on the subject.²⁷ The first, from W.P. Herringham, was clearly on the side of the judiciary and pointed out firmly that executive departments could not be law-makers. Moreover, he was willing to state categorically that justice was more important than the dignity of medicine or any damage that may be done to public health.

H. Wansey Bayly, a Harley Street doctor, took the opposite view: confidences should be kept at all costs. He indicated that 'not infrequently a married patient has

²⁴ PRO MH 55/184 Machlachlan memo 21 July 1927.

²⁵ *BMJ* 30 July 1927, p.194.

²⁶ *BMJ* 12 November 1927, p. 904.

²⁷ *Lancet* 30 July 1927, p.253-4.

asked me whether all information that is given will be treated in absolute confidence even in the event of legal proceedings being instituted in the future.’²⁸ This is an important example of the worry that lay behind the perceived need for privilege: that disclosure would undermine patients’ confidence in the system and deter them from seeking proper treatment. Wansey Bayly was an advocate of martyrdom, ‘willing to go to prison for conscience sake, as honourable men have so frequently been called upon to do in the past’.²⁹ Such eloquence in describing the principled martyr is reminiscent of another Harley Street advocate of martyrdom: the Dr Baley who made similar claims in the *Daily Chronicle* at the time of the *Needham v Needham* case.³⁰ Whether this was the same individual or not, his well advertised and patient attracting willingness to sacrifice himself to honour seems never to have been put to the test.

The third letter came from Graham-Little. Beyond McCardie’s ruling, Graham-Little had been aggrieved by what he saw as attempted encroachment-by-stealth into medical confidentiality. The House of Commons had recently considered a bill which contained a clause from the Corporation of the City of Liverpool that would have made it compulsory for doctors within the area to notify a public authority of patients suffering from VD. The clause, which would override the 1916 regulations, was part of a 136-page document and was only noticed at the last moment. Graham-Little believed that public opinion was ripe for a change in the law in favour of medical privilege, indeed it would be like ‘forcing an open door’.³¹

On the same day as Graham-Little’s letter was published the *BMJ* carried an article which recited the failed attempts to claim privilege in the early 1920s. It also extended the claim it had made a week earlier, stating that the only remedy left was special legislation which ‘should deal not only with venereal clinics, but with other regulations under which the same or similar questions arise.’³² The slide towards vagueness was already occurring. If they were to learn from the earlier debates, the medical privilege lobby would have to establish a clear definition of the legislation they sought. But experience indicated that ring-fencing an area where privilege applied would be exceptionally difficult. The difficulty would be compounded by the need to convince people that it merited overturning 150 years of case law which

²⁸ Ibid.

²⁹ Ibid.

³⁰ *Daily Chronicle* 19 November 1921.

³¹ *Lancet* 30 July 1927, p.254.

³² *BMJ* 30 July 1927, p.179.

provided a simple and categorical rule: in the interests of public justice there was no medical privilege.

For the next three months, the question lay beneath the surface, both in the medical press and at the Ministry. Personnel at the latter were aware that their first step had to be to address the case Birkenhead had advanced against medical privilege in 1922, and the lull in publicity on the issue masks the tactical thinking going on behind the scenes. A writer to the *BMJ* in mid-August, Alan Gemmell, suggested that legislation was the wrong route to take. Legislation was unlikely to provide the pro-privilege lobby with what they wanted and ‘as the problem has nothing to do with votes, Parliament would never find time for it.’³³ Honour was the key element for Gemmell and he joined those in favour of maintaining confidences even if it entailed martyrdom – raising, yet again, the analogy with penitent and priest. For R M Courtauld, however, the analogy was imperfect. Responding to Gemmell the following month, Courtauld provided reasons why the medical position was more contentious than the priest’s. For instance, the priest only knew what he was told whilst the doctor had the knowledge gained by virtue of his observation and training. Thus, the latter was the more valuable witness. Moreover, it was relatively easy to trace the doctor who had treated a particular patient when compared to the difficulties in establishing which priest had heard a penitent’s confession.

If the required doctor was as little discoverable as the required priest, and if his evidence was confined to relating verbal confidences that he had received from his patient, he would be as little troubled by subpoenas as is the priest.³⁴

The Ministry of Health were also looking at ways to avoid resorting to legislation to resolve the apparent conflict of interests. Writing in August, Slator summarised the position from the early interwar debate, noting in particular Birkenhead’s essay. He summarised Riddell’s address to the medico-legal society and the details of McCardie’s Birmingham ruling which had come just a month later. In light of all these, he foresaw no easy way to achieve the changes which had been sought in 1921. Rather than taking such a difficult route, Slator suggested a new solution which ‘while not solving the matter, would meet with less opposition and would minimise the harm

³³ *BMJ* 20 August 1927, p.329.

³⁴ *BMJ* 10 September 1927, p.470.

done to the venereal disease campaign'.³⁵ In an attempt to steer a middle course through the extremes of new legislation or medical martyrdom, Slator suggested that the evidence of VD medical officers could be heard *in camera*. Recent legislation was noted to have extended the courts facilities to hear evidence in private and Slator believed that private hearings would reduce the level of publicity which such cases received and consequently there would be less of a deterrent for patients seeking treatment.

Naturally, Gemmell and others who saw the matter strictly in terms of honour would not have been mollified by such an approach as doctors would still be breaking their patients' confidences. Duty requires the same action whether it is in public or private. From their view of ethics the fact that an action would not be widely seen did not affect its wrongness. But, just as Riddell had acknowledged that the law and ethics seemed at times irreconcilable, the Ministry were looking for a pragmatic approach. No scenario was likely to meet with universal approval. Therefore, rather than going down the difficult route of legislation, why not try to find the best angle on the *status quo*? The public had been most heavily involved in the subject when the newspapers had covered the divorce cases in which doctors had unsuccessfully claimed privilege. Their articles had suggested that the whole philosophy underpinning the treatment schemes had been put under threat – comments which had sparked the Ministry into action in 1920. If the negative publicity could be reduced, or even done away with, by having the evidence given in private, then the Ministry hoped to solve the problem without having to do the seemingly impossible by reconciling the warring factions.

A month later, Coutts was pointing to deficiencies in Slator's proposed position.³⁶ Giving evidence in private would presumably not prevent protest being made and, Coutts surmised, in all likelihood that protest would become public. While not questioning the undesirability of negative press, Coutts indicated that the history of the VD clinics showed little change in attendance despite the detrimental press coverage of cases like *Garner v Garner*. He suggested that the real problem was not sufferers being deterred from seeking treatment, but that VD medical officers were uncomfortable with their situation. The evidence certainly pointed towards more unrest amongst the VD doctors than the patients. The Ministry had received a number of complaints about the prominence of the guarantee of confidentiality on posters and

³⁵ PRO MH 55/184 Memo by FS 25/8/1927.

³⁶ PRO MH 55/184 Memo by Coutts 20/9/1927.

leaflets advertising the clinics in the early interwar years. The doctors involved in the high profile cases - Elliot in *Needham v Needham* and Assinder in the 1927 *Birmingham Case* - had clearly been made uncomfortable in their position relative to their patients. Assinder was threatening to withdraw the clinic's advertisements. Elliot had threatened resignation. Coutts suggested that they had taken too literal an interpretation of the regulations as binding them to absolute secrecy. In his view the regulations were intended to provide no more than a general rule of confidentiality because of the sensitive nature of the complaint and the importance of secrecy to its treatment.

Having seemingly argued against the case for medical privilege, Coutts then suggested that the resolution was best found in establishing the right for VD doctors to refrain from breaking confidences without patient consent. Criminal cases would be exempt from such a rule and there would be provisos for consultations made on behalf of insurance companies, and for doctors to defend themselves in malpraxis cases. Further exemptions might include a patient being examined at the request of a parent or employer, and communications with mentally defective or unsound individuals. Special measures would also have to be considered for pathologists who had to examine specimens for VD clinics. Thus, Coutts had moved from a relatively simple position – educate the VD doctors that secrecy was a rule that could be broken when giving evidence in court - to one in which VD doctors should maintain secrecy, even in court, but with a number of other exceptions. Experience indicated that the latter approach was likely to be more complicated.

The following day, Colonel Harrison, the Ministry's adviser on VD, wrote to Coutts with his interpretation of the situation.³⁷ In essence his argument was that VD treatment was an exceptional instance in which medical confidentiality was more important than medical testimony in court. In stressing the importance of encouraging sufferers to seek early treatment by guaranteeing confidentiality, he was speaking from a basis of knowledge:

Some instances in my own experience of men concealing their venereal disease, or their suspicions of such, for years are almost unbelievable. Often

³⁷ PRO MH 55/184 Memo by Harrison 21/9/1927.

enough in the meantime these persons have passed on their diseases to others, and frequently they have become mental wrecks.³⁸

It was not enough to assess whether people turned up at the clinics for treatment. Just as important was encouraging *early* treatment. Consequently, anything which cast doubt into the sufferer's mind that may result in a delay in seeking treatment would be of detriment both to the individual and possibly the community as well. Therefore Harrison argued that, save in criminal cases, anything which implied that the guarantee of confidentiality was not as extensive as it had seemed, would be detrimental to the treatment schemes and the community. Clearly, Harrison was making an argument based on personal knowledge and expertise rather than theory or conjecture and he claimed the support of 'all medical officers I know who are closely acquainted with the psychology of venereal patients.'³⁹

Doctors had previously presented the public interest case for allowing VD officers a level of privilege. Harrison would have known it would not in itself be enough. Rather than focussing solely on defending the medical position, he turned to attack the legal stance. Birkenhead and others had stressed the importance of medical evidence to the ends of justice. Treading carefully, Harrison ventured that medical evidence may not be helpful and indeed it could be 'positively harmful unless the judge and barristers possess the knowledge of a VD specialist.'⁴⁰ On a number of occasions the opinion had been expressed that the judge was best placed to decide when medical testimony was important enough to override confidentiality. Harrison was implicitly attacking this assertion by querying the extent to which legal minds had a sufficient understanding of the medicine involved to make an informed decision. Taking one of Birkenhead's hypothetical cases from 1922, Harrison outlined the difficulty of interpreting the medical evidence to prove with certainty which member of a couple had transmitted VD to the other. It is worth quoting at length his comments on the subject.

In most cases of the kind assumed here it would be very difficult to prove either A.B. or his wife were guilty. Assuming that A.B. had taken the steps most

³⁸ Ibid.

³⁹ Ibid.

⁴⁰ Ibid.

favourable to a decision by seeking medical advice at once for an early primary sore and, on the diagnosis being pronounced, having his wife examined at once, the evidence would have to prove not only the earliness of the husband's syphilis and the greater age (by weeks) of the wife's but also the finding of a primary sore in the wife in a situation, such as the cervix uteri, where it could have been acquired only by illicit relations. I venture to say that such a combination would not be discovered once in a thousand times. The most usual event, even when the husband had been so prompt as supposed, would be failure to find any primary sore in the wife, and even if she were proved to have acquired syphilis, it would be unjust to conclude that she had done so other than accidentally. In most cases the story starts with the doctor at a much later date when nobody can say with certainty which party was infected first; the evidence is extorted but proves nothing to an informed mind. In Birkenhead's case A.B. might go to the doctor with a relapse of a primary sore having been infected two or three months before and been treated by another doctor but having in the meantime infected his wife. The doctor's "simple sentence" might be to the effect that he found a primary sore on the husband and a syphilitic rash on the wife. The first conclusion, without careful cross-examination based on expert knowledge, could easily be that the wife had acquired the disease first and had infected her husband.⁴¹

Medical evidence should not, therefore, be seen as an easy route to the truth, as it could not always establish with any certainty the order of events which had led to the infection of either party. It is important to note that Harrison was not belittling medical expertise. Rather, in understanding the complexities of the disease, VD doctors were able to foresee the difficulty of using medical testimony to establish facts on which legal cases could be decided. It was their superior knowledge of the possible sequences of infection which led to their inability to provide strict factual evidence. The more they knew of the disease, the more they knew they could not be sure of its history of transmission.⁴² Following from this, if medical testimony did not serve the ends of justice in such cases and confidentiality was beneficial to the

⁴¹ Ibid.

⁴² Michael Worboys gives an account of some of the significant changes that were taking place in the understanding, perception and treatment of VD in the late 19th and early 20th century, in M Worboys, 'Unsexing Gonorrhoea: Bacteriologists, Gynaecologists, and Suffragists in Britain, 1860-1920', *Social History of Medicine*, 17, (2004), 41-60.

treatment of VD, then it was in the public interest for VD officers to have a privilege of secrecy.

As it turned out, the Ministry did not opt to follow the line taken by Slator, Coutts or Harrison. At a Cabinet meeting on the morning of 11 September, Chamberlain spoke to the Lord Chancellor (Cave) about medical privilege. Contrary to Addison's approach to Birkenhead in 1920, Chamberlain did not believe that legislation was required. Rather he suggested that the situation would be alleviated if the Lord Chancellor asked judges 'not to make a parade of their insistence of the evidence being given as was done by Mr Justice McCardie in the *1927 Birmingham Case*.'⁴³ Presumably this referred to McCardie's threat to subpoena the whole of the staff at the Birmingham hospital, which naturally attracted press attention. The Lord Chancellor agreed to talk to Lord Merrivale, the President of the Probate Divorce and Admiralty Division. This approach would help to solve the problem of doctors' perceptions that they were being unfairly treated by judges and also the press interest in open confrontation between doctors and the judiciary in the public arena of the courtroom. However, Robinson saw two outstanding issues. It was unclear if the BMA were going to press the matter and Robinson suggested that in light of Birkenhead's well-known hostility to medical privilege, it was best to keep them quiet. Moreover, if there was to be no legislation, there was still a question of whether anything should be done regarding the pledge of confidentiality given at the VD clinics. This had been a sticking-point for many of the VD officers and the Ministry's proposed action would do little to change that. Robinson's suggestion, endorsed by Chamberlain, was simple: 'I am for doing nothing and I do not think such passivity will do harm.'⁴⁴ High profile cases were infrequent and if the judges tempered their demands for medical testimony they should receive even less publicity. There was, however, one key unknown factor – the likely impact of Ernest Graham-Little's proposed bill.

The Medical Practitioners' Communications Privilege Bill.

Graham-Little announced his intention to introduce a bill on medical privilege in *The Times* on 14 November 1927. The following day he proposed to postpone the motion until 22 November, 'so as to give opportunity of further consideration of the measure

⁴³ PRO MH 55/184 Memo 9/11/1927.

⁴⁴ PRO MH 55/184 Handwritten note by Robinson 14/11/1927.

by all concerned.’⁴⁵ On the same day he wrote to Wood at the Ministry enclosing a draft of his bill.⁴⁶ Unlike the proposals which Dawson had advocated in 1921, Graham-Little was proposing to limit the legislation to communications made under the 1916 VD regulations. He stressed the strength of feeling, evident in the medical press, that there was a need for change either in the law relating to evidence, or in the regulations which guaranteed secrecy. The former was the preferred option, and his bill had the support of several MPs. If the Ministry was to support the bill, he believed its success would be assured.

The Ministry drafted a response to Graham-Little indicating that, despite its limited scope, the bill would raise the whole question of medical privilege ‘as to which there are marked differences of opinion.’⁴⁷ In the circumstances no guarantee of Ministerial support could be given. It is not clear whether this letter was sent, but Kingsley Wood did speak with Graham-Little before the date he was due to present his bill to the House of Commons. Noting that the question required careful consideration, Wood informed Graham-Little that parliamentary business would leave no time for his bill in the current session.⁴⁸ Clearly, Wood was trying to dissuade Graham-Little from pursuing the matter in Parliament in the same way as Robinson had dissuaded Dawson in 1921. Graham-Little was not so willing to comply.

Graham-Little was not the only one still concerned with medical confidences. The day before his bill was due to be heard in the House of Commons, a joint meeting of the Bournemouth Legal Society and the Bournemouth Division of the BMA was held to discuss whether medical confidences should be privileged in civil and criminal legal procedure.⁴⁹ The discussion was opened by Dr E K Le Fleming, who put forward three arguments for medical privilege: honour; public demand for it; and the example of most European countries and some American states. These, along with the other views put forward at the meeting, were well-worn arguments. Marshall Harvey of the legal society stressed the importance of medical evidence to legal proceedings and the role played by a doctor’s conscience. Dr L A Weatherley, asked to speak at short notice, pointed to a recognised medical privilege in Scotland. In this he was mistaken, as the Scottish courts, while accepting that confidentiality was an integral

⁴⁵ *The Times* 15 November 1927.

⁴⁶ PRO MH 55/184 E Graham-Little to Kingsley Wood, 15 November 1927.

⁴⁷ PRO MH 55/184 Draft reply to E Graham-Little, undated.

⁴⁸ PRO MH 55/184 Kingsley Wood to N Chamberlain, 21 November 1927.

⁴⁹ *BMJ* Supplement 3 December 1927, p.215-6.

part if the doctor – patient relationship, recognised that some circumstances justified breaching patient confidences. Disclosure at the demand of a judge in court was one such justification. Weatherly also suggested, as Slator had done at the Ministry, that evidence could be heard *in camera*. Mr D’Angibau of the legal society pointed out that it would be extremely difficult to change a law which had been in force since 1776 – the Duchess of Kingston’s ongoing legacy. While there did not seem to be too much agreement between the lawyers and doctors – Le Fleming suggested that the legal society were unable to refute his arguments for privilege – there was some. Mr Maud from the legal society supported privilege for both doctors and priests. But, with the standard broad arguments and divergence of opinions, Bournemouth did not provide a good omen for Graham-Little’s bill entering parliament the following day.

In the House of Commons on 22 November 1927, Graham-Little sought leave to introduce his bill. It was drafted in the following terms:

Be it enacted by the King’s most excellent Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same, as follows:-

1. Any information obtained by a duly registered medical practitioner in regard to any person treated for VD under a scheme approved in pursuance of Article II (2) of the Public Health (Venereal Diseases) Regulations, 1916 shall be regarded as confidential, and shall be privileged from disclosure under the court of law.

Provided that the information obtained shall have been obtained for the purpose of a cure or assisting in a cure, of a person so treated.

And provided also that this privilege shall not extend to any communication made with the object of committing or aiding in the committing of any fraud or crime.

2. For the purpose of this Act “Duly recognised medical practitioner” shall mean a person whose name is on the “medical register”.
3. This Act shall be called the Medical Practitioners Communications Privilege Act, 1927.

Graham-Little declared that the bill was aimed at removing the deadlock between the authority of the VD regulations and the judiciary over the secrecy of treatment at VD

clinics. Using information from the *Royal Commission Report*, Graham-Little made clear the prevalence of VD in Britain. He noted that it was the third biggest killer, after cancer and tuberculosis, 'and probably ought to come first as it predisposes in very many cases to those diseases'.⁵⁰ In strong rhetoric reminiscent of Birkenhead, he noted the extremely high mortality rates it caused amongst children. As well as 'slaying their tens of thousands'⁵¹, venereal diseases topped the list of disabling diseases, were responsible for a large proportion of cases of insanity and caused many diseases of the nervous system 'which make life a prolonged agony.'⁵² Again quoting the figures from the Royal Commission, he estimated 1 in 10 persons were infected, and that half of all cases of blindness in 'quite young children'⁵³ were attributable to VD.

When the VD treatment clinics had been set up after the report of the Royal Commission in 1916, the regulations had made clear the prime importance of confidentiality to the success of the scheme. In Graham-Little's opinion, all information at the clinics was to be regarded as 'absolutely confidential.'⁵⁴ A bold interpretation of article II (2), this was in keeping with the strong language he used to build the case for his bill. Modern treatment of VD had 'revolutionised' prognosis. Deterrence factors to treatment may cause 'irreparable' damage, presumably to patient and community. Two key factors were required for the success of the VD scheme: the enthusiastic co-operation of the doctors involved and the complete confidence of patients. A judicial ruling like that of McCardie in the 1927 *Birmingham Case* undermined both elements. Moreover, by implication any proposed remedy that did not guarantee *complete* confidence – a taming of the regulations for instance – would be detrimental. Graham-Little went further, suggesting that forcing VD doctors was not only a 'betrayal' of Hippocratic ethics, but was an affront to parliament, 'because Parliament must be responsible in some measure for the acts of one of the most important Ministries under the Government.'⁵⁵ Clearly, he was attempting to portray the situation as a stand-off between Parliament and the judiciary, rather than an inter-professional dispute between law and medicine. The

⁵⁰ *Official Report of Parliamentary Debates. House of Commons. Vol.210 (1927)*, p.1608.

⁵¹ *Ibid.*

⁵² *Ibid.*

⁵³ *Ibid.*

⁵⁴ *Ibid.* p.1609.

⁵⁵ *Ibid.* p.1610.

argument would have had more force if it had come from, or been strongly supported by, the Ministry itself.

Thus far in his speech, Graham-Little had adopted similar techniques to those Birkenhead had employed with such success in the early 1920s. His vocabulary and illustrations had evoked strong images of the need for absolute confidentiality – revolutionary treatment; irreparable damage; betrayal of trust; and children suffering the consequences. He even followed Birkenhead in being somewhat liberal in his interpretation of past events, claiming that his bill sought to sanction legally as privileged ‘communications which have been erroneously supposed during the past 12 years to be privileged.’⁵⁶ In light of the legal rulings against medical privilege of the early interwar debate, this was a highly dubious claim. For his finishing flurry, he presented a choice: either the law had to change or the regulations had to be scrapped. He had been assured by ‘eminent’ MPs that any legal difficulties could be ‘readily overcome’. If, however, the House opted to scrap the regulations, ‘the fate of a highly successful and important ministerial and medical effort is sealed.’⁵⁷ A first reading of the bill was agreed to, and the second reading was scheduled for the following Monday.

An almost verbatim account of Graham-Little’s speech in the House of Commons was published in the *BMJ*.⁵⁸ The correspondence pages of the same issue burgeoned with letters on the subject. Dr H Pinkhof from Amsterdam, while expressing appreciation of the line taken by Graham-Little, was amazed that he had been advised to restrict the privilege to cases involving VD. If such a limited privilege were granted, then anyone claiming the privilege was implicitly confirming the presence of VD. Pinkhof noted that the High Court of the Netherlands had recently granted doctors the right to refuse to give evidence in court after one practitioner had served as martyr for the cause and been imprisoned.⁵⁹ W G Aitchison Robertson, author of *Medical Conduct and Practice*, took a very different line. He thought far too much was made of claims to medical privilege and that it was right that judges, as accredited representatives of the King, had the power to demand medical evidence. The problem of negative publicity could be overcome by giving evidence in writing

⁵⁶ Ibid.

⁵⁷ Ibid.

⁵⁸ *BMJ* 26 November 1927, p. 1010.

⁵⁹ *BMJ* 3 December 1927, p. 1055.

or *in camera*. Otherwise the law should be accepted as it stood.⁶⁰ This letter confirmed the views expressed by Aitchison Robertson in his textbook of 1921. While recognising the importance of confidentiality to medical practice, he emphasised the importance of the doctor's duty to society by aiding the law in cases of crime or giving evidence during legal proceedings – in Aitchison Robertson's view Mansfield's ruling from 1776 'still holds good'.⁶¹

A lengthy letter was received from one of the participants in the Bournemouth discussion. Lionel Weatherly, having been given insufficient time at the Bournemouth meeting, wanted to use the *BMJ* to voice his 'very definite views on this burning subject.'⁶² He suggested that judges had less respect for medical secrecy than they had shown forty years previously. Weatherly opposed the BMA's position that general rules could not be laid down and he was also against martyrdom as a route to privilege. Rather, he supported Graham-Little's bill because it resolved the inconsistency between the Ministry's pledge of secrecy and the judiciary's demand that the pledge be broken and, also, because secrecy was so important in successfully combating VD. If evidence had to be heard – and each case where the question arose should be considered on its own merits – the evidence should be given *in camera*. In other words, Weatherly advocated a privilege for VD doctors, but if it could not be granted then the judge in each case should consider whether medical evidence, received at the price of deterring sufferers from seeking treatment, was really necessary. If it was, then the damage should be limited by keeping the proceedings as private as possible.

The *Lancet* also carried a summary of Graham-Little's speech. In an article on medical confidences in the same issue, it was stressed that privilege would have to be consistently applied.⁶³ Obviously thinking along the same lines as Pinkhof, the *Lancet* quoted the *Solicitors Journal's* belief that a privilege which applied only to VD treatment would be liable to provide evidence by implication whenever a doctor claimed privilege. Arguably, doctors should not even waive privilege at the request of the patient as it would have a negative reflection on defendants who chose not to consent to medical disclosure. The privilege would have to be sought on grounds of

⁶⁰ Ibid.

⁶¹ W G Aitchison Robertson, *Medical Conduct and Practice. A Guide to the Ethics of Medicine*, (London, 1921), Mansfield is quoted on p135.

⁶² *BMJ* 3 December 1927, p. 1055.

⁶³ *Lancet* 3 December 1927, p. 1190.

public interest, but, in the article's view, 'health is hardly a less urgent national need than justice.'⁶⁴

While the medical journals were assessing Graham-Little's bill, at the Ministry of Health Machlachlan instructed Slator to consult with the solicitors' branch and draw up a memo in response.⁶⁵ Slator acted on this the following day raising the following points for the solicitor to consider.⁶⁶ Would the proposed privilege prevent evidence being given where the patient consented to disclosure? Which patients would be covered by the privilege? Under the strict terms of Graham-Little's bill, only information relating to individuals *treated* at the VD clinics would be privileged. Thirty percent of people turning up at the treatment centres were found not to be infected so would presumably not be covered by the law. Similarly a number were diagnosed with VD who then abstained from treatment and so would also be denied privilege by the semantics of the bill. Slator also queried the purpose of the first proviso and the wording of the second proviso to the first clause.

On 8 December Slator wrote back to Machlachlan, indicating that the bill would need drastic redrafting and was, therefore, not worth devoting much time to. As example of the inadequacy of the draft, Slator pointed out that the bill would only protect communications between the doctor and patient, not the information which the doctor obtained by his own observations or from laboratory reports. He suggested that the first clause would be better re-worded as:

A registered medical practitioner shall not, except at the request or with the consent of his patient, be compellable in any civil proceedings to disclose any information obtained by him in the course of attendance on the patient at an institution or centre for the treatment of VD established by or under arrangements made with the local authority. Nor shall he be compellable, for the purpose of disclosing any such information, to produce any books or documents kept at such institution or centre.⁶⁷

This, in itself, would be insufficient if there were any documents in the custody of nurses or other staff which could be called as evidence in place of the doctor and his

⁶⁴ Ibid.

⁶⁵ PRO MH 55/184 Note from Machlachlan to Slator 2 December 1927.

⁶⁶ PRO MH 55/184 Note from Slator to solicitor 3 December 1927.

⁶⁷ PRO MH 55/184 Note from Slator to Machlachlan 8 December 1927.

records. It was pointed out that at large treatment centres the register of patients was filled out by a clerk on behalf of the medical officer in charge. Therefore, the clerk could be a valid witness. Other employees could also be liable to provide appropriate testimony:

an orderly who prepared a solution of arsenobenzene and saw the medical officer administer it to a patient whom he could identify in Court might be a useful witness if privilege was extended only to medical officers of the centre.⁶⁸

Clearly, the definition of the privilege would have to be more extensive than Graham-Little had envisaged – at the very least covering all staff and documents at the VD clinics.

At the bottom of the memo, a handwritten note from Machlachlan suggested that the matter could be put on hold as there was no likelihood of the bill making progress in the current parliamentary session. He was right – the bill did not resurface until nearly a decade later. Talk of legislation did continue in the interim. Vernon Davies, a keen supporter of Graham-Little's bill, approached the Ministry to get a clause inserted into a National Health Insurance bill in early 1928. Frustrated that there was insufficient time to get a general bill enforcing article II (2) of the 1916 regulations, Davies was attempting to get at least a legislative guarantee of secrecy for insured persons undergoing VD treatment, by inserting a clause in a bill that was already going through parliament. Coutts and Slator, who met with Davies, pointed out that such a limited applicability was illogical. While agreeing that uninsured persons should also have a guarantee of secrecy, Davies argued that insurance patients were often afraid to seek official treatment for VD and in the long-run this had a greater impact on insurance funds. Coutts and Slator suggested that Davies draft a clause and the Ministry could comment on whether they felt it worthwhile pursuing. Davies had a different plan. If the Ministry were to draft a clause along the lines which they felt best calculated to deal with the problem of secrecy and it was then to fall into his hands, 'he would receive it confidentially and introduce the clause as his

⁶⁸ PRO MH 55/184 Note from unnamed to Slator 9 December 1927.

own without making any reference to the Ministry.'⁶⁹ Having attempted puppetry with Elliot in 1921, the Ministry gave the impression they were not too keen to go along with Davies' plan. Coutts summarised their response as follows:

We mentioned the objections to such a procedure and did not encourage him to think that we should be able to do as he requested, but we promised that the matter should be considered in the department and that a communication should be sent to him.⁷⁰

Machlachlan asked Slator to contact Sir Walter Kinnear, controller of insurance and pensions at the Ministry of Health.⁷¹ Slator wrote back suggesting that any clause which sought to protect the secrecy of insured persons alone would be 'out of order'.⁷² Machlachlan passed this opinion on to Kinnear, who in turn persuaded Vernon Davies that 'we cannot deal with a general question of this magnitude in a NHI Bill.'⁷³ This negative response to Vernon Davies brought the question of medical privilege to a close as far as the Ministry was concerned.

An additional reason for the Ministry's reluctance to support medical privilege was the simultaneous rise of interest in the benefits of notification of VD. This campaign was driven from Scotland where there was considerable interest in adopting legal coercion to get patients to undergo early and full treatment. The Edinburgh Corporation (Venereal Disease) Bill that sought to implement these measures on a trial basis in Edinburgh received its first reading in the House of Commons in February 1928 and forced the Ministry of Health to seriously consider its merits. The bill did not succeed, being defeated by 156 votes to 93 on its second reading in the House of Commons after a 'lively' four hour debate on 19 April.⁷⁴ Its failure does not detract from the impact it had as a counterbalance to those lobbying the Ministry to support a bill aimed at medical privilege in cases of VD. It emphasised the fact that there were conflicting views on medical privilege, even in connection with VD and the Ministry would not solve its problems by supporting a bill like Graham-Little's.

⁶⁹ PRO MH 55/184 Coutts' memo 27 April 1928.

⁷⁰ Ibid.

⁷¹ PRO MH 55/184 Machlachlan to Slator 27 April 1928.

⁷² PRO MH 55/184 Slator to Machlachlan 28 April 1928.

⁷³ PRO MH 55/184 Machlachlan to Kinnear 30 April 1928; Kinnear to Machlachlan 3 May 1928.

⁷⁴ R Davidson, *Dangerous Liaisons*, 191.

However, while the Ministry had long since lost the desire to pursue the question of medical privilege, for others the question of legislation was still open. Speaking to the St Pancras members of the BMA in October 1928, Graham-Little announced his intention to reintroduce his bill, claiming he had 'received some encouragement from the Government Whips'.⁷⁵ The fact that the Ministry of Health had closed their file on the question makes this an unlikely move from the Whips, but, if accurate, they were amongst other voices giving support for Graham-Little's bill.

At the Royal Institute of Public Health in January 1928, Lord Justice Atkin expressed support whilst presiding over a discussion on the position of medical witnesses. Roland Burrows, a lawyer, gave a speech entitled 'the medical practitioner in relation to the administration of justice', in which he expressed the opinion that there was insufficient reason to grant doctors privilege. Drawing attention to the uneasy relationship between lawyers and medical witnesses, Burrows acknowledged that 'on occasions counsel did seem to have overstepped the limits of decorum'⁷⁶, but often medical witnesses seemed, *a priori*, to object to cross-examination. Cross-examination was important in establishing the strength of the evidence, and it was a key reason why medical evidence could not take the form of a written report. Burrows suggested that a doctor should understand the case before he took to the witness stand so that he could have clear in his own mind what information was relevant and could be stated as fact. He should also be conscious of not overstepping the mark with inference or hypothesis, making clear when he was simply expressing opinion. There is something in Burrows words that is strongly reminiscent of the textbook writers on medical jurisprudence of the nineteenth century. The idea that medical witnesses were uncomfortable in the witness stand, facing questions which probed how much they knew and could be sure of their subject.

Lord Justice Atkin stressed the importance of medical evidence to the justice system and suggested that, as a group, doctors received sympathetic treatment from the courts. Agreeing with Burrows that often cross-examination was difficult for medical witnesses, Atkin proffered his own golden rule: make clear when you are not sure of the evidence you are giving. Such an approach would leave the witness in a stronger position. As for medical privilege, Atkin placed the claims of justice on one side of the balance and those of public health on the other. In his opinion:

⁷⁵ *The Times* 11 October 1928.

⁷⁶ *BMJ* 28 January 1928, p.136.

In some cases, especially in connexion with venereal disease, he was of opinion that the claims of public health far outweighed the claims of justice, and he would be quite glad to see even the very small change in the law that was sought to be introduced by Dr Graham-Little's bill.⁷⁷

This was more than empathetic rhetoric. When Graham-Little made his second attempt at introducing medical privilege legislation in 1937, Atkin had drafted many of the bill's clauses.

One hour and forty minutes on a 'not altogether unusual'⁷⁸ Friday afternoon.

Given the voices calling for medical privilege in the months following the first reading of Graham-Little's bill in 1927, an explanation is needed as to why it took a decade to reappear. Certainly, the government had not made it a priority and judging by the memos at the Ministry of Health, they were hoping that the matter would fade away. However, in announcing his intention to make a new attempt at legislation in '37, Sir Ernest Graham-Little, as he now was, gave his main reason for putting his bill on hold a decade earlier:

I did not proceed further with the early Bill, as inquiries convinced me that even if the Bill passed the Commons, the Lords, led by Lord Birkenhead, would reject it. I believe there will be less opposition now from legal members of both houses, and this belief, as well as another consideration, has weighed with me in making my new Bill of wider application.⁷⁹

Clearly, Birkenhead's shadow had loomed large in Graham-Little's mind in 1927. Birkenhead's death in 1930 lessened the obvious barriers to medical privilege. From the time of his early involvement in the debate as Lord Chancellor, Birkenhead had been the leader of opposition to medical privilege. His essay in *Points of View* had become a kind of talisman for the anti-privilege cause and a warning for those who sought to change the law. His presence in the House of Lords at the time of Graham-

⁷⁷ Ibid.

⁷⁸ Mr Dingle Foot's assessment of the situation at the time of Graham-Little's bill being discussed in Parliament. *Official Report of Parliamentary Debates. House of Commons*. Vol. 319 (1936-7), p.1995.

⁷⁹ *BMJ* 6 February 1937, p.302.

Little's first drive for legislation was clearly a disincentive to the bill's supporters who chose rather to bide their time. Though his written words remained, the loss of Birkenhead's presence and considerable debating skills, coupled with support from prominent lawyers, would certainly increase the chances of a new attempt at legislation being successful. Moreover, by 1937 Birkenhead was not the only key figure to have been lost from the anti-privilege lobby of previous debates. Henry McCardie, responsible for two important precedents against the concept of medical privilege, died in 1933.

Graham-Little was not, of course, simply waiting for the key opponents of his bill to die. Beaten by the demands on parliament's time in 1927, he had taken stock of the measure he was proposing. His bill had been, by his own admission, a reactionary response to McCardie's ruling in the *1927 Birmingham Case*. Seeing a public health problem arising from a conflict between the 1916 government regulations and the judicial ruling, Graham-Little had, on the advice of legal friends, limited his proposal to cases involving VD treatment alone. On further consideration he realised that with such a limited definition, any plea for privilege would by default confirm an allegation of VD. Clearly this was unsatisfactory, and the privilege would have to be given a broader definition. Graham-Little was able to use his expertise in dermatology to investigate what that broader definition should be.

In 1935, the Ninth International Congress of Dermatology was held in Budapest. Graham-Little presided over a committee appointed by the congress to consider medical problems affecting public interests. As one of the subjects for discussion, he asked members of the committee to indicate the degree of protection given to medical confidentiality in their home country. With most European countries represented, along with the United States, Graham-Little felt the result was quite clear. In a letter to the *BMJ* on 1 February 1937, he summed it up as follows:

It became obvious that the protection given to the "professional secret" abroad was much more efficient than in our own courts, and no miscarriage of justice from this protection was recorded by the various speakers.⁸⁰

⁸⁰ Ibid.

In November 1936, Graham-Little's bill had been read for the first time. Its wording was almost identical to that of the long title of the 1927 bill: 'to provide that certain communications between medical practitioners and their patients shall be privileged from disclosure in evidence in courts of law.' Being no more than a formal notification of the bill, the first reading gave little indication of the extent and application of the privilege Graham-Little was going to propose. With the date of the second reading set for 5 February 1937, Graham-Little was using his letter to the *BMJ* to indicate his intention to push for a more extensive privilege than he had sought in 1927, and to reassure doubters that, given the experience of other countries, medical privilege would not be followed by untoward results.⁸¹ In fact, this letter was not published until the day after the debate took place in parliament.

At 1.40 p.m. on 5 February 1937, Graham-Little requested a second reading for his Medical Practitioners' Communications (Privilege) Bill in the, far from busy, House of Commons.⁸² His introduction outlined the development of the debate throughout the 1920s, stressing the importance of secrecy to VD treatment. He cited the report of the London County Council which indicated that in one year there had been 1,050,000 attendances at VD clinics in the area, emphasising the scale of the public health question involved.⁸³ While he cited other areas in which medical secrecy was needed, Graham-Little was basing his bill largely on the circumstances which had arisen around McCardie's ruling in the 1927 *Birmingham Case*. This was where his problems in persuading the House, began. He described his new attempt at legislation as 'very much the same'⁸⁴ as his 1927 bill but without the restriction to VD cases only. However, while touching on the need for protecting medical information in other circumstances – young unmarried mothers afraid of stigmatisation; or national health insurance patients' medical records for example – the greatest time and detail was given to a reiteration of the arguments over VD. The familiar arguments came to the fore – a rise in the number of divorce proceedings and an extension of the ways in which medical evidence, particularly of VD, could be useful, led to a rise in the demand for medical testimony. Consequently the guarantee of medical confidentiality was being broken on a regular basis and this undermined confidence in the VD

⁸¹ *BMJ* 6 February 1937, p.302.

⁸² At one point the discussion was interrupted while the number of MPs was counted to see if there were forty present. *Official Report of Parliamentary Debates. House of Commons*. Vol. 319 (1936-7), p.1995.

⁸³ *Ibid.*, p.1982.

⁸⁴ *Ibid.* p.1987.

treatment scheme. Drawing on his investigations into the position in other countries, he cited examples in which secrecy was recognised by the law in other countries with little damage for justice. The Academy of Medicine had reaffirmed this as the French position in 1927. In order to emphasise international consensus over the protection of medical secrecy, Graham-Little indicated that the dermatology congress in Budapest had passed a resolution stating that medical confidences should be legally protected from disclosure except in cases of crime.

Having put forward the case as to why medical privilege should be recognised, he gave two options as to how it could be achieved. Either it could be established in common law or by statute law. The former approach had proved unsuccessful – judges had always ruled against medical privilege. There was the option of pursuing a common law precedent via the martyrdom route but Graham-Little was not a strong advocate of this, favouring ‘alteration by quiet, orderly Parliamentary procedure [rather] than in response to an explosion of public opinion which may or may not occur, but which is not the best way to reform abuse.’⁸⁵ Reform not revolution was the way advocated by Graham-Little, but his words did seem to carry the implied threat that martyrdom was always a possibility. Anyone opposing his current bill would have to consider a scenario of public outcry as judges sent doctors to prison because parliament had refused to go down the peaceful route of legislation.

Despite claiming to have had the bill vetted by ‘one of our most eminent judges’⁸⁶, Graham-Little finished by offering a potential compromise. If MPs were unwilling to accept the bill’s wider scope, he would be willing at the committee stage to limit the application of privilege to VD cases. While on the face of it this seemed to demonstrate a reasonable willingness to compromise and reach the best solution, in fact, it was simply illustrating the vagueness that constantly shrouded the definition of medical privilege. Graham-Little’s arguments had stressed that his previous bill which focussed on VD was not sufficient. He had ventured examples of other settings in which medical secrecy had to be protected in court and pointed to the fact that other countries benefited from medical privilege. Yet, he finished by saying his original bill would be available as a compromise – thereby negating his previous arguments. Unsurprisingly, the opponents of the bill noticed the inconsistency.

⁸⁵ Ibid. p.1992.

⁸⁶ Ibid. p.1990.

Graham-Little had taken 36 minutes to expound on the merits of his bill. By contrast, Lovat-Fraser took only seven minutes to second it. Searching for the earliest precedent on the question, he had found the Duchess of Kingston case. While citing Lord Mansfield as ‘probably the greatest judge who ever administered justice in this country’, Lovat-Fraser emphasised that the law as set down in that precedent had to be altered. This was not because, having examined the details of Caesar Hawkins’ plea, Lovat-Fraser had realised that common law precedent was built on shaky foundations, rather, he simply thought that there should be a medical privilege like that given to lawyers, spouses and public officers. He cited Justice Hawkins’ endorsement of the concept of medical secrecy in 1896 as further support for privilege – a somewhat liberal interpretation of Hawkins’ remarks. On the whole, he kept his speech succinct, indicating that really all that needed to be said had been put forward by Graham-Little.⁸⁷

In contrast, Dingle Foot, MP for Dundee, was detailed and lengthy in proposing an amendment that the second reading of the bill should be delayed for six months.

Those of us who have looked at this Bill find ourselves in a position which is not altogether unusual on a Friday when Private Members’ Bills are introduced. We can, of course, sympathise with the objects...but it does seem to me and to some of my friends who have examined the Bill that those who are its sponsors have entirely failed to appreciate what the consequences would be if the Bill passed into law.

Foot was implying that, despite having had almost a decade to clarify his original bill, Graham-Little and his cohort of supporters had presented an ill thought through proposal. In fact, Foot suggested that it would have been better if they had stuck to the terms of their original bill, which had, at least, made clear when the privilege would be applicable. The new bill granted the possibility of privilege to safeguard information gained in a professional capacity, without any specific guidelines as to how a determination of the applicability of privilege would be made in each case. This gave the strong impression that the privilege was more that of the doctor than of

⁸⁷ Ibid. p.1994.

the patient which clearly negated any analogy with lawyer/client privilege. This vagueness was one of the key criticisms Foot had of the bill. In addition, he portrayed the situation *vis-à-vis* VD, the main problem which the proposed bill sought to remedy, in a very different light. Quoting the *Lancet*, Graham-Little had painted a picture of significant growth of divorce cases in which medical evidence was required. By contrast, Foot's characterisation of the situation was that VD only occasionally arose in divorce cases. Yet, even if they accepted Graham-Little's compromise of limiting privilege to VD cases only, there would still be problems. Foot pointed out that, if medical evidence was essential for a wife to prove her husband had knowingly infected her with VD, then the narrower bill would prevent that medical evidence being given. Thus:

If you have the possibility of disclosure on the one side it is a hardship, and I agree with that statement, but in the instance which I have just put forward we have a hardship on the one side and a hardship and an injustice on the other.⁸⁸

This was a poor characterisation of the equation. Foot lumped the personal detriment to the patient, the professional affront to the doctor and the potential damage to the VD treatment scheme (and by extension public health) into one 'hardship'. Correcting this misrepresentation should have been the pro-privilege lobby's response, but, instead, Vice-Admiral Taylor queried a semantic distinction as to whether the bill did not only prevent disclosure of what doctors had been told. That would allow the doctor in the example Foot had given to recount what he had learned on his examination of the patient, thereby allowing justice to be done. Foot seized this opportunity to drive home his point:

The hon. and gallant Member, whose name is on the back of the Bill, ought to have read the Bill.... How ridiculous it would be for the doctor to be called, and say: "Yes, this man was suffering from this disease, but I have found it out for myself and he did not tell me. Therefore, there is no privilege attaching to it."⁸⁹

⁸⁸ Ibid. p.1999.

⁸⁹ Ibid. p.2000.

The proponents of the bill were themselves demonstrating its protean nature and thereby highlighting the vagueness which their opponents had pointed to as its chief weakness. His case more or less having been made for him, Foot finished by drawing attention to the corner into which the supporters of the bill had been talked:

I can only suggest that those who drafted the Bill did not appreciate the effect of what they were doing. If they did appreciate it, it appears to me that it would not merely be a case of righting a wrong, but it would almost amount to conspiracy to defeat the ends of justice.⁹⁰

Having managed to unsettle the pro-privilege lobby, Foot sought to mix fear with confusion and thereby seal the fate of the bill.

Seconding Foot's amendment, Ernest Evans – MP for the Welsh universities – further emphasised the lack of public demand for medical privilege. In his view, public apathy meant there was no need to get bogged-down in a debate over the relative demands of public health and justice. The bill sought privilege for the doctor not the patient, and this could prove detrimental to the latter as the bill did not make clear that patient consent would override the privilege of the doctor. Thus, to agree the bill would be to give the medical profession 'a privilege to which they are not entitled, and what is much more serious, imposing upon them a responsibility which I should imagine very few of them would wish to have.'⁹¹ So, in addition to possible unfairness to the patient and interference with justice, the bill would give doctors an added burden of controversial responsibility which they may not want.

Again, the pro-privilege lobby's response was less than robust. Sir J Withers suggested that, just as in the case of solicitors, the court could decide when medical privilege applied. His response to the accusations that the privilege was more the doctor's than the patient's was tentative at best: 'if the Bill goes to Committee and is dealt with sympathetically, I am sure this question of privilege, whether it is of the doctor or the patient, could be cleared up.'⁹² Seeming to play on the sympathy which had been expressed at the difficulty of the doctor's position by opponents of the bill, its supporters pointed to the committee stage as the area where the complexities could

⁹⁰ Ibid. p.2001.

⁹¹ Ibid. p.2003.

⁹² Ibid.

be ironed out. Given the unease demonstrated by the pro-privilege lobby when the bill's foundations were questioned, the impression is given that, Graham-Little's lengthy introduction aside, they had assumed that the bill would get to Committee stage where the real debate would take place.

The penultimate speaker was Sir Terence O'Connor, the Solicitor-General. Speaking with the authority of position, his arguments again expressed the problems of interpreting the bill. Imperfect as the current situation was, it certainly would not benefit from the new difficulties which could arise under the proposed legislation. That, in short, was the key problem: finding a definition of privilege which would overcome the perceived shortcomings in the current situation, without creating a whole new set of problems of equal or greater consequence.

I think the promoters of the Bill, when they came to describe what privilege was, found themselves in the same difficulty as I should be in if I attempted to put into statutory form any of the safeguards of justice⁹³

This was the crux. Since 1914, those in favour of medical privilege had struggled to encapsulate with any exactitude the privilege they sought. Legal privilege was recognised in the common law and had not needed to go through the complex procedure of defining itself in a specific enough way to satisfy parliament that it should be written into statute. By contrast, common law precedent recognised no privilege for medical practitioners – a situation stemming (arguably, falsely) from the Duchess of Kingston's case. Being the first attempt at getting statutory privilege for a profession, O'Connor suggested that an already complex bill would be further complicated by amendments at the committee stage which sought clauses dealing with the secrecy of communications to members of the clergy.⁹⁴ The analogies which had been used to bolster the cause of privilege in the past were coming back to haunt it in O'Connor's speech. The clergy would complicate the bill and may prevent it getting through committee stage, and a prominent member of the judiciary was openly stating that he did not think legal privilege could be well enough defined to pass as statute law— though, of course, it did not need to be. O'Connor's position was clear:

⁹³ Sir Terence O'Connor. Ibid. p.2005.

⁹⁴ Ibid. p.2007.

I venture to think that I am not overstating the matter when I say that there is hardly any branch of the law, civil or criminal, in which the passage of this Bill in anything like its present form would not impede the administration of justice.⁹⁵

An hour and a half after it began, H G Williams, became the final speaker in the debate. He stressed that, while he understood Graham-Little's intentions were connected not with professional self-interest but with the difficulty arising from the demands on medical information, nonetheless, the proposed bill was vague. Did it entail that doctors were bound to absolute secrecy or that a court could not compel disclosure? If a doctor could choose when to disclose information, this would open up the possibility of a doctor blackmailing his patient. Doctors demanding money in order to provide their patients with the evidence relevant to their cause would be a rare occurrence in what was perceived as an honourable profession. Yet, even the possibility of such a position was intolerable. A better outcome would be if a doctor called as witness who felt he had strong justification not to give evidence could, privately, give his reasons and let the judge decide whether evidence should be heard. There was no need of legislation to achieve this and Williams finished by presenting a positive slant on rejecting the bill:

I have no doubt that those eminent in the law will take notice of the discussion, and, possibly, where the practice has been defective it may be improved as a result of the debate⁹⁶

Williams' opinions had been expressed without interruption or objection from the bill's supporters. In voting, the House voted against an immediate second reading and in favour of the amended time of six months. Effectively, this was a rejection of the bill as it would fail to reach conclusion by the end of the parliamentary session and thus would have to be introduced afresh. That Graham-Little asked leave to withdraw his bill, is an indication that he had been persuaded of its well-intentioned inadequacy. After an hour and forty minutes deciding the fate of medical privilege, the House

⁹⁵ Ibid. p.2006.

⁹⁶ Ibid. p.2011.

turned its attention to the abolition of the tipping system for waiters, chambermaids and porters in hotels and restaurants.⁹⁷

Conclusion

Graham-Little's 1927 attempt at legislation got further than Dawson's in 1922. While the Ministry of Health had dissuaded Dawson from introducing the question in the House of Lords, they did not manage to convince Graham-Little to keep it out of the Commons. His determination to proceed with his private members' bill is testimony to the strength of feeling that the issue of medical confidentiality still provoked. The relative powers of the judiciary *vis-à-vis* ministerial regulations were continuing to cause tension, and discussions like that of the medico-legal society in early 1927 emphasised the lack of a resolution to the question in 1922. Birkenhead's essay had been a key factor in blocking the promoters of a stronger definition of medical confidentiality at that time, but it had not satisfactorily resolved the underlying difficulties between the competing interests. McCardie's ruling at Birmingham brought press attention to bear on the discrepancy between article II (2) of the VD regulations and the overruling of this by judges in the growing number of divorce cases, thereby making more public an issue which had continued to be debated in professional circles. While there continued to be marked differences of opinions over medical privilege, there was also evidence of a higher level of cross-professional support. Riddell certainly thought there was a case to be made for a limited privilege, and Atkin lent the weight of his support to the 1937 bill. Both bills received the support of some lawyers in the Commons – an important step considering that a greater number of MPs came from legal than from medical backgrounds.

While Graham-Little was to cite the lack of time on the parliamentary agenda, and the threat of a hostile House of Lords (led by Birkenhead), as the reasons for the failure of his first attempt, the key factor was undoubtedly the lack of ministerial support. The specificity of the focus on giving statutory protection to a governmental regulation in the 1927 bill, made the lack of visible support from the Ministry of Health a highly conspicuous shortcoming. From their file, it seems that the memory of the difficulties which the Ministry had experienced in trying to extend the boundaries of confidentiality in the early interwar years was still too fresh in their mind. In

⁹⁷ Hotels and Restaurants (Gratuities) Bill. Ibid. p.2011.

contrast to Addison, a quiet word to the Lord Chancellor requesting that judges tone-down their demands for medical evidence was as much as Chamberlain was willing to do.

By contrast, supporters of privilege resorted to more extreme measures to get a statutory privilege for doctors, Vernon Davies' attempt to get a clause inserted into a national health insurance bill being a notable example. But it was not until late 1936 that Graham-Little got another chance to promote the cause in the Commons. Having used the intervening time to investigate further the question, particularly at the conference in Budapest the previous year, his new bill sought to emulate the broader concept of medical secrecy that he had found dominant in Europe and certain states in America. Making it a stage further than he had done in 1927, Graham-Little's request for a second reading of his 1937 bill was met, not unjustly, by queries about its scope, applicability and intent. Avoiding the minutiae of the problems that needed to be addressed, presumably because of the difficulty of the task, the bill had been framed in broad terms in the hope that it would receive a second reading and could have its finer points defined at the committee stage. But, broad, in this case, meant vague and the critics of the bill had little difficulty in demonstrating that even the signatories of the proposal had conflicting views of what it would mean in practice. Graham-Little's offer to confine the terms of his bill to VD alone if it would prove more satisfactory only compounded the confusion, coming, as it did, after arguments as to why the broader privilege was needed. By the end of the discussion in the Commons, it was apparent that Graham-Little had himself been persuaded of the inadequacies of his proposal. Hope for legislation would temporarily have to turn into hope that the *process* of seeking legislation would itself have caused a change in judicial perception. The boundaries of medical confidentiality were no nearer to being defined in a wholly satisfactory way, and there would continue to be issues and questions probing away beneath the surface. Having familiarised themselves with the 'snakes' of statutory change, any future promoters of medical privilege in parliament would have to focus on the 'ladders' of skilled legislative craftsmanship and ministerial support.

Chapter 8 – The varied context of medical confidentiality

Introduction

The issue of VD dominated the debate between the BMA, the judiciary and the Ministry of Health over the boundaries of medical confidentiality in the early interwar years and was still evident at the times of Graham-Little's two attempts at legislation. However, its prominence as an issue should not obscure the fact that questions relating to medical confidentiality were being raised in a number of different contexts in the interwar years. What follows illustrates some of the various contexts in which questions of medical confidentiality arose. These range from the position of ship surgeons in the enclosed community on a sea voyage, to the confidentiality of medical records relating to mentally ill patients. Examination will also be made of the impact of a significant change in the divorce law through the Matrimonial Causes Act of 1937. Two specific legal cases will also be looked at. The case of the 'Kissing Doctor' will examine the position in relation to medical confidentiality of a doctor called to defend himself against allegations of improper conduct. A review of the coroner's inquest into the death of Vera Evelyn Norris in 1938 will question the extent to which progress had been made in clarifying the doctor's duty to notify suspected cases of criminal abortion since the Royal College of Physicians' consultation with Clarke and Avory in the late nineteenth century.

Andrew Morrice has already drawn attention to many of the queries which made a relatively brief appearance in the minutes of the BMA central ethical committee in the interwar years. These ranged from the demand that doctors break secrecy to help the police inquiry into the Brighton Trunk murder, to interpretations of who was allowed to be present in the room during the medical examination of children at school.¹ One key example which Morrice did not select was the position of ship surgeons with regard to confidentiality at sea. With its empire, Britain had a large mercantile fleet and a major interest in emigrant and passenger liners. A high number of ships meant that a temporary placement as a ship surgeon was a relatively common occurrence for young medical graduates. Crowther and Dupree estimate that 1 in every 10 medical graduates from Glasgow and Edinburgh universities took on a post

¹ A Morrice, 'Honour and Interests: Medical Ethics in Britain and the Work of the British Medical Association's Central Ethical Committee, 1902-1939', 280-283.

as ship surgeon.² As relatively young and inexperienced doctors they were particularly vulnerable to questions of medical ethics. It is with this significant class of medical practice that analysis will begin.

Blowing the whistle on Ocean Liners

In writing the preface to the first edition of his *Ship Surgeon's Handbook* in 1906, Vavasour Elder asserted that 'no class of men undertake their professional duties knowing less of the surroundings in which these are performed than surgeons going to sea for their first voyage.'³ The positive response evoked by this guide prompted a second edition in 1910, by which time Elder had made the substantial addition of five chapters, including one on medical logs. Commenting on this chapter in the preface, he noted that 'special attention has been paid to the question of "professional secrecy" in relation to ship-surgeons, as it has always seemed that the prevailing custom at sea is somewhat at variance with generally accepted rules of procedure, and one, moreover, which should be settled by a medical authoritative body.'⁴ In 1914, the BMA council attempted to do just that by publicising the following decision: 'That professional secrecy should be maintained by ship surgeons in respect of all cases of illness attended by them on board, except in those cases of illness which come within the quarantine regulations of any port visited or other legal obligations.'⁵ Yet, despite this clear-cut statement by an authoritative medical body, the CEC were still receiving queries about medical secrecy on passenger ships in the interwar years. This section examines the question of confidentiality in regard to ship surgeons, showing how it fits into a broader picture of discontent amongst the profession over the perceived value and status of seagoing doctors.

In 1912, the *BMJ* drew attention to the deficiencies in medical provision on certain classes of emigrant ships. Referring to the 'large tide' of emigration flowing out of England destined for Canada and Australia, it pointed to the implications for the medical profession. In addition to the ordinary passenger liners - which were enjoying year round high passenger numbers - another class of ship was tapping in to the boom in demand. 'The majority of emigrants are being carried in vessels purely of

² Information supplied by M A Crowther and M Dupree on the basis of their late 19th century database of the careers of Glasgow and Edinburgh medical students.

³ A. Vavasour Elder, *Ship Surgeon's Handbook* (London, 1927) Preface to first edition p. 11.

⁴ Ibid. p.9.

⁵ As noted in BMA CEC minutes 1 June 1937.

the cargo-boat type, temporarily fitted – according to legal specifications of course - for the carriage of emigrants on the outward passage. Homeward bound they revert to their original function.’⁶ Carrying around double the number of passengers of ordinary liners, these cargo ships had caused a rapid increase in the demand for ship surgeons to look after the ‘1400 to 1500 souls on board for a period of six weeks in continually changing climatic conditions.’ The Merchant Shipping Acts recommended that ships carrying more than 1300 “statute adults”⁷ should have more than one medical officer, but as the ships reverted to non-human cargo on the return journey, they were not required to have a medical officer unless the crew amounted to greater than one hundred people. For this reason, at least one, but often both, of the medical officers on board the ship would be doctors who were themselves emigrating and sought passage work. In light of Elder’s warning of the unforeseen challenges of medicine at sea, the idea that inexperienced passage-work doctors should be employed to deal with such large numbers of passengers was problematic.

Outlining the heavy workload, the poor living and working conditions and the potential strain of dealing with epidemic disease on board, the *BMJ* noted that the surgeon was an ‘important official...vested with powers which are almost paramount should he consider it necessary to enforce them.’⁸ While such a description suggested the utility of employing experienced ship surgeons, steamship owners were businessmen whose primary concern was profit. The cost of using an experienced ship surgeon was greater than giving free passage to an emigrating doctor willing to undertake the relevant duties in return. Thus, not only did passage work doctors get a bad deal, they also denied more experienced ship surgeons employment opportunities and allowed ship owners to fill the position on the basis of minimising running costs. The article’s conclusion was simple: ship surgeons must demand better pay.

It remains, as in other instances, entirely with members of the medical profession, either as permanent or as temporary ships surgeons, to demand adequate remuneration for the work they perform.... Shipowners are business

⁶ *BMJ* 21 September 1912, p.734.

⁷ A “statute adult” was equivalent to one adult person or two children between the ages of one and twelve.

⁸ *BMJ* 21 September 1912, p.734.

men, and cannot be expected to drive any but business bargains. Medical men are in duty bound to their profession to do likewise.⁹

This dual concern over the pay and status of ship surgeons was to dominate coverage of the issue in the *BMJ* in the years that followed. In March 1913, a letter from Manchester indicated that there was a general movement to raise the scale of pay for all ship's officers and, thus, made it 'the time for a master stroke from the medical profession as regards its seagoing members.'¹⁰ The author called for a unified approach which sought better pay and the establishment of a minimum wage for ship surgeons. The following week, another writer called for the BMA to take the lead, 'for unless the matter is taken up by the whole profession it is useless for individuals to strive for higher pay.'¹¹ Acknowledging that one of the problems in establishing a wage rate was the broad spectrum of ships on which a surgeon could be employed – from the luxury liners who might retain a professional ship surgeon, to the makeshift emigrant ships which gave an emigrating doctor free passage in return for his services – the author recounted the conditions he had recently experienced as medical officer on a round trip from Glasgow to Canada. Firstly, he had to examine the majority of the 300 passengers and vaccinate those with no sign of a previous vaccination mark. With bad weather on the crossing, there was a very high incidence of seasickness and bad colds with the result that he was working 'almost all day.' On the journey back to Glasgow these problems were exacerbated by the outbreak, amongst crew and passengers, of scabies. However, it was not only the amount of work but the conditions which caused difficulty. Describing the quarters which he had to visit to treat the firemen, the writer explained: 'they all lived and ate in a small dirty unventilated cabin where the air was thick with tobacco smoke, and a heavy foul odour seemed to overcome me when I entered.'¹² If ship owners and the wider medical profession were made aware of these conditions there would soon be a rise in the ship surgeon's salary.

Professional unity was again stressed by a letter published in the *BMJ* at the end of March. Whilst noting that demand for ship surgeons exceeded supply and that consequently there had been a rising trend in wages, the author reiterated the problem

⁹ Ibid. p. 735.

¹⁰ *BMJ* 1 March 1913, p. 472-3.

¹¹ *BMJ* 8 March 1913, p.532.

¹² Ibid.

of passage workers undercutting more experienced ship surgeons: 'Any sensible person must see that the action of these two classes of doctors tends seriously to lessen the social and professional standing of doctors generally.' The writer's proposed solution was that doctors should only accept ship surgeon's posts through a medical agency promoted by medical schools and the BMA alike. No such scheme was established, but the *BMJ* did engage a policy of refusing to print adverts for ship surgeon's posts if the proposed wage was less than £10.

The issue of remuneration was further blurred by the policy of some shipping companies to allow the ship surgeon to charge for attendance on first and second class passengers. This meant that the monthly wage paid to the medical officer on board was not a simple indicator of how much money the doctor made. Indeed, the impression given was that ships which paid less in wages per month but allowed the doctor to charge non-steerage passengers for private attendance were actually more profitable for the doctor.¹³ This was not guaranteed, as the additional income depended upon the health status of the first and second class passengers. Nonetheless, for some the answer to the financial problems experienced by ship surgeons lay not in seeking a minimum wage but in uniting to establish a fixed scale of fees reflecting the class of passenger treated. 'Now is the time if there are any regular ship surgeons in the vertebrate division, to combine and make their terms,'¹⁴ suggested one writer who again pointed to the imbalance between supply and demand of seagoing doctors. This apparent deficit is of interest as it represents a significant change from the late nineteenth century. It is possible that the employment opportunities afforded practitioners by the National Insurance scheme were diverting them away from getting early experience in ship surgeon's posts. Obviously, the First World War significantly reduced the number of doctors available for civilian passenger ships but that would not have been an issue in 1913. Whatever the reasons for its existence, there was a possibility to use the undersupply of ship surgeons to negotiate better terms for their employment. All that was needed was some spine.

Certainly, some shipping companies did not expect stiff opposition from their surgeon. One correspondent to the *BMJ* enclosed a letter from the owner of a ship on which he was about to sail.

¹³ *BMJ* 8 March 1913, p. 532.

¹⁴ *BMJ* Supplement 5 June 1913 p.56.

Dear Sir,

You are employed on board this steamer as medical adviser to the crew and passengers from the time she *leaves here until her return to this port*. Your special duty, among others, is to give all possible *professional attention* to the crew as well as the passengers, so please see this is done. Should the Master find it necessary to report neglect on your part in this respect, we shall have to treat the matter seriously and in a form that will be as disagreeable to you as to ourselves.

Yours faithfully.¹⁵

There was clearly a growing body of opinion that a concerted effort was required to improve the lot of the ship surgeon, both in terms of the financial remuneration of the post, and in the status of the position on board ship. A deficit in supply to demand for surgeons presented a context conducive to negotiating terms and the final ingredient would be professional unity on the issue. The BMA was taking action to this end. In 1912, its annual representative meeting had set £10 as the base wage appropriate to the work of ship surgeons and had subsequently refused to publish any advert offering less. It encouraged other medical journals to do the same. In addition to these preventive measures, a system had been set up to include 'appointments deemed to be undesirable'¹⁶ in the warning notice published weekly in the *BMJ*. The BMA's ship surgeons' subcommittee stated it would be 'glad to have, from ship surgeons or others interested, prompt information as to cases in which these officers are being treated unfairly.'¹⁷

Despite these actions, letters continued to appear in the *BMJ* complaining of the pay and working conditions for surgeons aboard ships.¹⁸ The ship surgeons' subcommittee reiterated their commitment to tackling these problems through warning notices and requested that prospective ship surgeons support the cause by passing on information to the BMA and, importantly, by not accepting any position that offered less than the recommended minimum of £10. However, it seems that concerns had spread beyond pay and status into the territory of medical confidentiality on ships. The committee made clear that the rules of professional secrecy were to be

¹⁵ *BMJ* 14 June 1913, p.1304.

¹⁶ *BMJ* 5 July 1913, p. 4.

¹⁷ *Ibid.*

¹⁸ *BMJ* 18 Oct 1913, p.1048. & 25 Oct 1913, p.1124.

maintained by ship surgeons for both passengers and crew members; 'in other words, information as to the nature of a case should be withheld from the captain unless it be one falling within the quarantine regulations of any port to be visited, or other legal obligations.'¹⁹ This statement was reiterated as a recommendation to the medico-political committee in the supplement to the same issue of the *BMJ*, and formed the basis of the BMA council's pronouncement on the rule of secrecy for ship surgeons given in 1914.²⁰

Letters continued to arrive in 1915. In early October, 'Nauticus' suggested that one of the obstacles in the path of doctors becoming ship surgeons was the 'expense of providing' and 'indignity of wearing a uniform which places them in the same category as a purser or second engineer.'²¹ In contrast to the description of the powers of the ship surgeon given by the *BMJ* in 1912, 'Nauticus' claimed the surgeon had no authoritative status on board ship and that consequently the uniform was no more than 'a badge of servitude to the company.'²² Doctors would far rather be regarded as something distinct from the crew of the ship and if shipping companies did away with the requirement of the uniform they would receive more applications from 'self-respecting' practitioners. The following week, 'Nauticul' suggested that 'Nauticus' had been too generous in his description of the ship surgeon's place in the ship's hierarchy:

To compare their status on board ship with that of a purser or second engineer is an insult to these occupations. The surgeon's status on board is that of the second steward or ship's barber. Their cabins are generally placed next to the latrine, and invariably on a lower deck, where ventilation in rough weather is impossible...even our premier passenger liners have allotted to their surgeons a cabin placed in such a disgusting position that the ship's builders could only have built it for the latrine attendant.²³

In the same edition 'Nauticus Olim' took issue with the idea that the uniform was an unnecessary obstacle. The surgeon must have a distinctive badge to identify him as

¹⁹ *BMJ* 8 Nov 1913, p.1246.

²⁰ *BMJ* Supplement 8 Nov 1913, p.396. For details of the 1914 pronouncement, see f.n.3.

²¹ *BMJ* 9 Oct 1915, p.556.

²² *Ibid.*

²³ *BMJ* 16 Oct 1915, p.592.

such and while first and second class passengers could be treated as private patients, the surgeon was employed by the ship's owners to treat third class passengers and crew. On this basis alone, and regardless of whether the surgeon had to wear a uniform, he was 'the servant of the owners and subject to the jurisdiction of the commander.'

This series of letters illustrate concisely the factors that were troubling the medical profession and also how the matter affected the question of medical confidentiality. Pay and status were traditional medical concerns. Nauticus's letter expressed discontent that ship surgeons were not being given the respect they deserved as members of the medical profession. Rather than being linked to the menial members of the ship's crew, they should be given separate recognition as 'doctor on board'²⁴ – a title which would associate them with an established profession with considerably higher status than second steward or barber. But, while 'Nauticus' claimed that it was the uniform which represented the servile status of the ship surgeon, 'Nauticus Olim' made clear that it was the terms of employment by the ship's owners. First and second class patients may be treated independently as private patients, but, as employer of the surgeon, the shipping company and, by extension, the ship's captain, claimed a right to the doctor's knowledge of the health of the passengers and crew of the ship. The surgeon's inferior status, therefore, had implications which went beyond the concerns of remuneration or pride and more firmly into the area of professional ethics.

'Twixt devil and deep sea.'²⁵

In his chapter on medical logs, Elder made clear the difficulties that faced the ship surgeon with regard to medical confidentiality. In addition to the standard consideration of the interests of the patient and the surgeon, 'the extraneous factor of third parties has to be considered at sea.'²⁶ Typically, the third party was the ship owner or quarantine or immigrant official. From the ship owners' point of view, there were three key concerns. They had to be aware of crew members who could not carry out their work on medical grounds; they had to protect themselves against complaints about the medical attention on board their ship from passengers or crew; and all

²⁴ *BMJ* 9 Oct 1915, p. 566.

²⁵ Elder's assessment of the ship surgeon's position when required to give medical details about his patients to third parties. A Vavasour Elder, *The Ship Surgeon's Handbook* (London, 1927).

²⁶ *Ibid.*, 341.

departments on the ship, including the medical department, were required to provide written evidence of the satisfactory performance of their duties on every voyage. In addition to these concerns, quarantine and immigrant officials required ship surgeons to notify them of passengers suffering from particular diseases, a list of which was set by each country. Clearly, the ship surgeon's position with regard to confidentiality was complicated.

Elder suggested that the only reason the profession had not sought clarification was the relative infrequency of court cases involving medical secrecy at sea – further confirmation of the importance of the law in determining the boundaries of medical confidentiality. Nonetheless, in such cases, the surgeon was caught between liability for damages to the patient, if he revealed professional details, and being sacked by the company, if he refused. The matter was further complicated by the fact that the ship surgeon occupied three roles with three levels of responsibility. As medical officer to the ship as a community, the surgeon had the right of entry into any cabin on board ship if he believed there was a person suffering from a dangerous disease. As medical attendant to the crew and third class passengers, he had a right of entry granted by the Board of Trade – but one he must be careful not to abuse. As medical practitioner to first and second class passengers, he had no more right to intrude on their privacy than a doctor on land. The ship surgeon's role therefore 'requires very careful playing to prevent him being considered unduly officious on the one hand, and yet to be fully aware of what is occurring on board his ship from a medical standpoint on the other.'²⁷

As a rule, Elder suggested that any first or second class passenger staying in their cabin for longer than forty-eight hours should be reported to the surgeon by the cabin attendant who would then decide whether to make an official visit. Elder did not agree with the idea that first class passengers should be left without interference. In his experience these passengers were more likely to leave the ship to "see the sights" at foreign ports and thereby bring contagion back on board, unlike the third class passengers who were examined both on embarkation and during the voyage. However, the fact that he had to stress the point suggests that often a class distinction was drawn. Dealing with first class patients was not always a straightforward business, not least because some had a preconceived dislike of ship surgeons.

²⁷ Ibid. 351.

Therefore, a first class passenger who remained in her cabin for forty-eight hours may indeed be unwell but not necessarily with a disease which threatened the well-being of the ship's community which would entitle the doctor to demand right of entry. Elder recommended that the doctor ascertain as much information as possible on the condition of the passenger and, if a consultation seemed advisable, to approach any other doctors on board to see if they would agree to participate. It was stressed that no professional offence should be taken at a first class patient's unwillingness to consult the ship surgeon, but that, if another doctor was consulted, the surgeon should be present. In part, this was because he would have to supply any drugs or appliances, but also, because his position entitled him to be aware of what went on.

Infectious disease posed a particularly acute problem on ships and immediate isolation of patients was the key to combating it. Unlike other cases of disease, epidemic disease, particularly when it involved children, should, in Elder's view, be made public. This would allow parents to take any precautions they felt necessary to protect their children. From experience, Elder had discovered that parents preferred to know straight away of any dangers. Smallpox was another instance where immediate notification was deemed wise. This allowed isolation of the patient and all 'contacts' and enabled those who wished to be vaccinated to receive early consideration.

Venereal disease was given special consideration by Elder. An official report that a crew member was suffering from VD would result in his removal from service when the ship returned to its home port. While in some cases this was necessary for the benefit of the crew as a whole, the fear of being entered into the 'log' would be a deterrent for crew members consulting the surgeon. As Roger Davidson relates 'seamen often concealed their infections from ships' surgeons for fear of victimization from their employers or from other members of the crew.'²⁸ However, the crew would be unlikely to submit to any physical examination to search for cases of VD so the surgeon had to rely on voluntary disclosure and work to minimise deterrents. Seeing VD as a 'sociological factor deserving a more comprehensive and broader understanding by all than is usual in England,' Elder stressed that the doctor had to be neutral – treating both the clinical and social causes of the disease but never acting as a 'moral scourge to his patients. Rather let him enact the role of true

²⁸ R Davidson, *Dangerous Liasons*, (Amsterdam, 2000), 67.

physician – guide, philosopher and friend.’²⁹ Thus, for Elder the balance of interests between notification of VD and minimising deterrence was best found by the surgeon in each particular situation. This mirrors the thinking of the central ethical committee of the BMA in the early interwar years, when they advocated that each practitioner’s conscience should be the guide to best practice on confidentiality. However, in the small, enclosed community at sea, conscience was often tempered by pragmatic considerations: ‘to dismiss all venereal cases indiscriminately is tantamount to stopping a ship for want of crew, or perhaps depriving her of some of her best workers.’³⁰

The final area of concern for ship surgeons with regard to confidentiality was the keeping of medical records. There were two key reasons for keeping records of all medical attendance. In the first instance, as previously stated, the medical department of the ship had a responsibility to demonstrate to the ship owner that they had carried out their duties in line with the terms of their employment. Some dubiety existed as to whether the ship owner’s entitlement to medical information stretched only as far as the crew and passengers who were treated free of charge, and did not cover first and second class passengers who opted to pay for private treatment. For Elder, there was no ethical distinction between gratuitous and paid attendance. Both the surgeon and the ship owner had an interest in keeping records of all medical attendance in order to counter any complaints or claims for compensation against either the company or the individual surgeon:

In support of this it may be stated that claims are pending personally against the writer in American courts at the present moment for considerable amounts, for alleged malpractice in the treatment of passengers, and which are being contested on the strength of full records being kept.³¹

While the keeping of records was clearly important, it brought with it the problem of who had the right to access them. The considerations of the ship owner’s right to the evidence of work, and the need for a record as a form of legal protection had to be balanced by concerns for patient confidentiality. While some elements of medical

²⁹ A Vavasour Elder, *Ship Surgeon’s Handbook*, (London, 1927), 350.

³⁰ *Ibid.*

³¹ *Ibid.* 345.

practice differed from land to sea, the belief that any encroachment into medical confidentiality would result in patients' natural reticence hindering efficiency applied in both contexts.³² Consequently, Elder recommended different forms of record. The official report for the ship owner should contain only the name and class of patient, the date of first and last attendances and a column for remarks including the result of treatment. The ship owner would, therefore, have an index containing the list of work performed by the surgeon. The surgeon himself should keep a private day book in which he would enter the name, symptoms, diagnosis and treatment of all visits he made to patients, noting in particular the date of cure or discharge. This would be kept by the surgeon for reference and as protection against legal proceedings and not presented to the ship owner as an official report. In addition, a special book would be kept to record all accidents and serious cases which would constitute special reports.

Throughout his writing, Elder worked on the assumption that the ship owner was interested only in general medical information about both passengers and crew. If he required any detail beyond the fact that a passenger received medical attention between certain dates, or that the crew were being adequately dealt with, he would have to make direct representation to the surgeon. Elder believed that such information would be of no interest to the ship owner in normal circumstances and 'is so decidedly contrary to the ethics of medical practice.'³³ Even where members of the crew were considered unfit for service, the report which the ship's surgeon provided to the owner could be presented with a minimum of medical detail. Elder's own practice was to compile a list of men unfit for service in each of the ship's departments and submit it under the following heading: 'The undermentioned should not be re-engaged, on medical grounds.'³⁴ Written in triplicate, the original would be sent to the head of the department concerned without the addition of the medical details regarding each case. These details would be inserted on copies two and three, before the former was sent to the medical superintendent of the shipping company and the latter was filed in the surgeon's own records. Elder believed that a second opinion was needed before a man was rejected from service on a ship but was adamant that the opinion should come from a doctor with sea experience as 'there are many men in

³² Ibid. 341.

³³ Ibid. 348.

³⁴ Ibid.

the mercantile marine doing hard and continuous work who would never be passed for duty on service standards, or even those obtaining in civil employ on land.’³⁵

The combination of roles which the surgeon carried out in the enclosed community of a ship demanded special consideration of his duties *vis-à-vis* confidentiality. As medical officer, he had to think in terms of the welfare of all members of crew and passengers and break confidentiality in cases of contagious disease. As employee of the ship owner, his dealings with the crew and third class passengers had to be related to the company as evidence of fulfilling the terms of his service and also in case of complaint. However, it was clear that the rules governing certain diseases – notably VD – were subject to a large measure of individual interpretation, and that the scale of the problem amongst seamen made strict adherence to a policy of notification all but impossible. In order to balance the interest of various parties in the medical information from a ship with considerations of confidentiality, the surgeon had to keep a number of record books. For the shipping company, only the most general information should be supplied, while for the doctor’s own records, a more detailed account should be kept in case of legal complaints about treatment. As if the ship surgeon’s position was not complicated enough, Elder’s assumption that third parties were only ever interested in general information about medical treatment aboard ship was to come under attack in the interwar years.

Gossip, Scandal and Rumour Spreading! Queries to the BMA central ethical committee on secrecy at sea.

A highly contrasting picture of medical provision at sea, to that described by correspondents to the *BMJ* prior to the First World War, accompanied an enquiry to the central ethical committee in February 1925.

The company in question has made rather a specialty of its medical service, the medical staff on each ship including trained nurses, a dispenser, a hospital attendant and in some cases a qualified masseuse. The equipment is very

³⁵ Ibid. 349.

complete and includes a laboratory outfit with incubators, various culture media etc.³⁶

While such specialty would not be standard, it nonetheless demonstrated that medical provision could be seen as an important and valued element of the ship's service. However, some things showed little signs of having changed. There was still an underlying worry about litigation against shipping companies for poor medical provision and as a result some required 'the most complete and detailed' records to be kept on the treatment of all passengers and crew. Although this was correct procedure from a medical point of view, the writer indicated that the company for which he worked required their ship surgeons to submit these records to the ship's commander for daily inspection. Unsurprisingly, the writer saw this not only as a breach of medical etiquette which might lead to legal proceedings against the surgeon, but also highlighted that such a policy was a deterrent for people 'requiring attention for illnesses of a special nature.'³⁷ Clearly this was not the form of general report that Elder had advocated. The writer stressed that the submission of such an 'intimate' report was not the policy in most shipping companies. The fact that it was in the company for which he worked meant that the majority of the crew, as insured persons dependent on the ship surgeon for their medical attention, could not seek medical advice on the same terms of strict confidence which they would experience on shore. However, any surgeon who failed to keep a complete record of all cases treated, despite protestation from the patient, would be open to severe reprimand. The writer sought the CEC's opinion so that he could either approach the medical superintendent of the company to get the practice abolished or reassure the medical officers who had queried their position of the correctness of the practice.

The central ethical committee asked if the writer would have any objection to their communicating with the company in question. He consented to this with two qualifications. He wanted no publicity or record kept of the name of the company – Canadian Pacific Steamship Ltd. - in connection with the query, and he wished that any decision which the BMA reached would be communicated directly to him as he had made the approach independently of his senior. Both these qualifications are significant. The latter places the query in the category of whistleblowing – itself an

³⁶ BMA CEC minutes 24 Feb 1925.

³⁷ Ibid.

interesting ethical question. While the BMA records still contain the name of the company in question, there is no mention of the name of the individual, which, given the verbatim inclusion of his correspondence, suggests a deliberate attempt to preserve his anonymity. The demand that the shipping company should be given no negative publicity indicates that the employee was not dissatisfied with the company or his terms of employment in any general sense. On the contrary, he had a very high regard for the company 'which otherwise has done more to raise the status of the medical officer at sea than probably any other steamship line. In fact, it is the present high standard of medical service which makes the regulation in question so objectionable.'³⁸ There is therefore both a link and a distinction, in the writer's mind, between the status of the ship surgeon and the ethics of medicine at sea. Status was a necessary precursor to influencing the company's policy on confidentiality. However, having achieved high status within the company, the medical officers were still concerned with the policy on secrecy because of its contravention of their understanding of medical ethics. Status and ethics were linked but separate issues.

Re-enforcing the significance of status, the writer indicated that the practice of giving the ship's captain access to detailed accounts of the ship surgeon's work was a remnant from 'by-gone days when it was thought necessary to have some check on the surgeon to ensure he was carrying out his duties.'³⁹ The fact that not all companies continued the practice was taken to be evidence that it was no longer necessary. Rather than the captain providing a check on the surgeon, the policy of giving all medical information to the captain increased the chance of sensitive information slipping out. In that regard, the captain was now more of a liability than the surgeon. The CEC tended to agree with this assessment and resolved that 'the action of the company in requiring medical records to be submitted to the ships' commanders is inimical to the public interest and a violation of professional secrecy.'⁴⁰ Consequently, the CEC resolved to support the employee who had raised the question. By May, the committee had received word that, as a result of their opinion relayed to the company through the anonymous employee, the Canadian Pacific Steamship Company had discontinued the practice. This must represent the most easily obtained and clear-cut success that the central ethical committee enjoyed on the issue of

³⁸ Ibid.

³⁹ Ibid.

⁴⁰ Ibid.

medical secrecy in the interwar years. As previously noted, the BMA had attained much respect as a result of their organisation of medical provision during the First World War. It is likely that this enhanced reputation as an authoritative body played a significant role in the Canadian Pacific Steamship Company's readiness to follow the BMA's recommendations. Naturally, the report was received with satisfaction by the CEC members.⁴¹

The CEC's success, though significant, was limited in application to the Canadian Pacific Steamship company. In June 1937, another request on secrecy at sea was received. Its author, Dr Meighan, presented his query in a similar manner to previous writers. Shipping companies had a vested interest in the health of their workforce which made it impossible to preserve medical confidentiality for members of a ship's crew, but Meighan argued that a greater measure of secrecy should be allowed to passengers. He noted that some companies still required their surgeons to present the ship's captain with a daily written or verbal report describing all the cases of illness on board 'which is usually followed by much inquisitive questioning by the Captain.'⁴² Acknowledging that secrecy was difficult to maintain at sea, Meighan pointed to the fact that many ship captains 'fancying themselves (from previous "experience" on cargo ships) as amateur "doctors" even suggest treatment!'⁴³ The surgeon's position was difficult as the captain had influence: 'the captain always has the ear of the head office, to whom a word from him may mean dismissal.'⁴⁴

Without a test case for breach of medical secrecy at sea, Meighan wanted to know where the boundaries of patient confidentiality lay. The CEC responded by sending Meighan a copy of the decision of the BMA council from 1914. Meighan wrote again, re-emphasising his objections and reiterating a request that the matter might be considered by the ship surgeons' committee. The CEC saw no reason to change their opinion. They re-affirmed the decision of council from 1914, further commenting:

the master of a ship has a special responsibility for the welfare of the crew and passengers and may reasonably expect to be informed of any event likely to be hurtful to their welfare. Most certainly a doctor in attendance on a patient on

⁴¹ BMA CEC minutes 12 May 1925.

⁴² BMA CEC minutes 1 June 1937.

⁴³ Ibid.

⁴⁴ Ibid. Emphasis as in original.

board ship is not less bound than his colleagues on shore to respect his patient's confidence and to abstain from any communication either to the master or to any other person which would be to his patient's disadvantage – subject to the general considerations herein stated.⁴⁵

Recognising that the master of a ship had a right to medical information, even detailed medical reports in exceptional circumstances involving the welfare of crew or passengers, the resolution suggested that in ordinary circumstances the ship surgeon should respect patient confidentiality. Meighan felt this response too vague and general to be of practical assistance. Echoing the sentiments expressed by Dr Burton, the medical officer of health in Ilford in the early interwar years, Meighan complained 'I feel that the members of the standing subcommittee (of the central ethical committee) have had little or no experience of a ship surgeon's work.'⁴⁶ The master of a ship could compel his surgeon to answer questions about his patients. The P&O company required daily information on the nature of illness and condition of every patient on board. Moreover, these factors were exacerbated by 'the magnified inquisitiveness of most Captains about illness and how to treat it.'⁴⁷

Meighan saw no easy solution in extending the duty of confidence to ship captains, who did not seem to rate very highly in his estimation. 'If he is informed, it is soon all over the ship,'⁴⁸ Meighan suggested in his first letter. He was yet more candid in his description by July: 'my present captain is a 1st class gossip-, scandal-, and rumour-spreader.'⁴⁹ He suggested that the BMA should write to the Board of Trade to ask that ship captains be instructed to adhere to strict rules of medical confidence, and to request that ship surgeons receive a right to withhold information considered detrimental to the patient. On receiving this communication from Meighan, the CEC invited the ships surgeons' subcommittee to review the correspondence. This it did on 1 March, concluding that 'there was nothing in the regulations governing the relations between a ship surgeon and the captain of the ship which would violate professional secrecy.'⁵⁰ No further action was taken.

⁴⁵ Ibid.

⁴⁶ BMA CEC minutes 6 July 1937.

⁴⁷ Ibid.

⁴⁸ BMA CEC minutes 1 June 1937.

⁴⁹ BMA CEC minutes 6 July 1937.

⁵⁰ BMA CEC minutes 8 March 1937.

The debate over medical confidentiality at sea was not insignificant. It highlighted a connection between the status of the doctor within the ship's crew and the relative weight that was placed on professional ethics. The pre-War drive to improve the status and conditions of ship surgeons was tied-in with concerns over their obligation to give information to individuals above them in the ship's hierarchy. By calling for professional unity, an attempt was made to improve respect for the ship surgeon's position. Rather than being seen in the lowly, servile position described in pre-War correspondence in the *BMJ*, ship surgeons would be recognised as members of a learned profession. By extension, the ship surgeon would also be bound by the profession's code of ethics – an important element of professional identity. Thus, the doctor who helped provide the excellent medical service for passengers travelling with the Canadian Pacific Steamship Company was still concerned with the company's policy on medical confidentiality even though he was otherwise very satisfied with his position.

Status was also important for the level of confidentiality given to passengers aboard ship. While Elder believed first class passengers should not be given special consideration in this regard, it is unlikely his advice was followed in practice. Many of the correspondents on the subject distinguished between giving information to the shipping company regarding members of the crew or steerage passengers who had received free treatment, while respecting the confidentiality of first class passengers who paid for private treatment. The isolation of a patient with an infectious disease was much easier in the case of first and second class passengers who had private cabins – mirroring the class distinction regarding the notification of infectious disease on land.

The Case of the Kissing Doctor

A central problem faced by the advocates of medical privilege was the recognition that there were circumstances in which medical confidentiality should be breached. For instance, the dictates of medical ethics did not prevent a doctor accused of misconduct from mounting a defence simply because professional information was bound by strict rules of medical confidentiality. During the meetings of the professional secrecy committee in 1922, the BMA lawyer, Turner, had expressed his concern that the drive for privilege might result in doctors either being unable to mount a defence in malpraxis cases, or employing a double standard which allowed

breach of confidence to protect professional reputation but not in other cases. The case of the Kissing Doctor provides an example of the basic need of doctors to be able to speak about their professional life when involved in legal proceedings connected to their professional reputation. Moreover, while individual conscience was often held up as the guiding light for doctors, the Kissing Doctor illustrates that the medical profession was not without eccentric characters whose perception of correct action would not necessarily be in keeping with majority opinion. Conscience may illuminate different paths for different practitioners.

In June 1921 the case of *Vidal v Vidal and Wilson* was heard before Sir Henry Duke, President of the Divorce Court. Edward Vidal was petitioning for divorce from his wife, Primrose Violet Vidal, on the grounds that she had committed adultery with Dr Arthur W Wilson (the Kissing Doctor). The case was decided against the petitioner. Wilson subsequently brought a libel action against twenty one individuals who lived nearby the Vidal's home, for writing a letter to the Vidal's landlord alleging that the house had been used as a brothel and that Wilson visited it almost every night. The case was heard in the High Court before the appropriately named Justice Darling. Wilson was aged between fifty and sixty, his wife was an invalid and, in addition to his private practice, he had a substantial panel practice which provided him with a good income. In court, Wilson's lawyer portrayed him as a generous character always looking to help out patients in whatever way he could, including sharing his love of music with them

He was often heard singing on his rounds, and it was no uncommon thing for him to sing in his patients' houses. He asked them whether they would like a little music and then he carolled forth to cheer them up. There could be no doubt that he was very odd.⁵¹

Wilson had known Primrose Vidal since he had been called in to visit her after a miscarriage in 1916. It was not just the frequency of Wilson's visits to Primrose Vidal's house that provoked suspicion, Wilson also paid the rent, rates and taxes and had paid for singing lessons for her as well as giving her a gold ring for improved singing. His pseudonym as the kissing doctor came from his practice of kissing his

⁵¹ *The Times* 9 March 1921.

female patients, a point best left for explanation by Wilson's evidence under cross examination by Mr Thomas during the hearing:

Thomas: After you first met her (Mrs Vidal) you acquired the habit of kissing her, a woman who, owing to the exigencies of the war, was separated from her husband?

Wilson: Yes.

Darling: Is this a habit you practice with all your patients?

Wilson: Not all; with many, when I got very friendly with them.⁵²

Wilson further acknowledged that he had kissed Primrose Vidal in bed. He assured the court that he had not done this often and it was only because she was a very dear friend.

Darling – Don't you realise that a doctor who necessarily must go into the bedrooms of women is in a very delicate position with regard to them?

Wilson – Yes

Darling - And that ordinary men would strongly object to a man's coming in and kissing their wives?

Wilson – It depends upon how these things are done, My Lord.⁵³

Unfortunately, Wilson did not elaborate on the appropriate way in which to enter the bedroom of a married woman and kiss her without provoking objection from her husband. Later in his evidence, Wilson indicated that there were 'about two dozen of his patients whom he quite frequently kissed without anyone's objecting. He could mention numerous patients also on whom he had spent money.'⁵⁴ Suspicious as the whole story sounds, it illustrates a salient point. Because a doctor's work involved matters of a sensitive nature he was open to litigation from a number of angles. One of the reasons that the medical privilege lobby had difficulties defining the boundaries of what they sought was because doctors often needed to be able to stand up and defend themselves in court. It was difficult to portray this exception to medical privilege as anything but a double standard grounded in professional self-interest.

⁵² Ibid.

⁵³ Ibid.

⁵⁴ Ibid.

It is simple to see how the circumstances involving Wilson and Primrose Vidal could be construed in a very bad light, but it is also possible that Wilson's motives were entirely altruistic. As Primrose Vidal testified, 'she knew of no other man who had done for her what he did without exacting something from her in return.'⁵⁵ Her father testified that he had no objection to Wilson kissing his daughter or his wife, 'the doctor often kissed them both.'⁵⁶ If a doctor was bound to absolute secrecy he would not be able to stand in court and give his side of the argument. Moreover, Wilson's accepted eccentricity demonstrates that there was no uniform mould for doctors. The central ethical committee's decision that, with specific guidelines on confidentiality impossible, individual doctors should rely on their conscience to guide them, would struggle for consistency in a world of practice that included figures like Arthur Wilson.

As an interesting aside, there were further legal ramifications to the failure of Vidal's divorce case. The loss of the case infuriated Edward Vidal's father, Vitale Benvenisti. Originally from Turkey, Benvenisti had become a naturalised British subject in 1897. A tobacconist by trade, he had been declared bankrupt in 1907. Believing that there had been a conspiracy against his son, Benvenisti decided that the best way to get the evidence for this claim was to antagonise the judge from the case, Sir Henry Duke, into suing him for libel. In order to achieve this, he printed one thousand copies of a pamphlet accusing the President of the Probate, Divorce and Admiralty Division; three firms of solicitors; a barrister and Dr Wilson of defrauding the courts of justice. Not content with this, he also employed two men to parade outside the courts in Carey Street and in Parliament Square throughout the day wearing sandwich boards which read

Is Judge Sir Henry Duke Afraid to Prosecute Me? I accuse him to be a traitor of his duty and of having defrauded the Courts of Justice for the Benefit of the Kissing Doctor.⁵⁷

As well as attention for his cause, these antics resulted in a CID tail for Benvenisti. With no let up in his persistence, eventually Benvenisti was brought before a

⁵⁵ Ibid.

⁵⁶ Ibid.

⁵⁷ PRO MEPO 3/379. A picture of one of the men wearing the sandwich boards in the street is included in the file.

Divisional Court consisting of the Lord Chief Justice and Justices Avory and Sankey. He reiterated his claims that the solicitors had been incompetent and left his son with inadequate counsel during the divorce hearing, and that subsequently Dr Wilson had attempted to bribe Edward with £200 and an agreement to provide him with evidence of his wife's adultery with another man in an undefended suit, if he agreed not to give evidence against him. Sir Henry Duke was accused of being so keen to get the Kissing Doctor off the hook, that he had abused his position and colluded in the judgement of not guilty. These arguments did not impress the Lord Chief Justice, who in his judgement stated

The defendant adhered to and insisted upon the allegations he had made, which were scandalous abuse of the worst description, and that he (Benvenisti) had expressed no regret and therefore in the circumstances the Court ordered that he should be committed to prison for four months for contempt of court.⁵⁸

Although the circumstances surrounding the Kissing Doctor's encounter with the law were exceptional, the case illustrates that doctors needed to breach confidentiality to defend themselves against allegations of improper practice. Vavasour Elder emphasised this when, as noted in the last section, he pointed to the fact that he was contesting a number of allegations of malpraxis on grounds of having kept full medical records. The knowledge that professional self-interest was a valid ground for breaching confidentiality was therefore a constant restraint on the advocates of medical privilege.

Inviting doctors to prophesy: the Matrimonial Causes Act 1937

The most publicised threat to medical confidentiality in the early interwar years was judicial insistence on the evidence of doctors from VD treatment centres during divorce hearings. The liberalisation of the divorce law in England was a slow process. In 1923, women were given access to divorce for adultery on an equal basis with men, but it was not until 1937 that the grounds for divorce were themselves extended to include three years' desertion, cruelty and prolonged and incurable insanity.⁵⁹ The

⁵⁸ PRO MEPO 3/379. Letter from Inspector Cooper to Chief Inspector Metropolitan Police 16 Oct 1922.

⁵⁹ Phillips, *Putting Asunder*, (Cambridge, 1988), 526.

Matrimonial Causes Act was a private members' bill that Alan Herbert, MP for Oxford University and a leading campaigner for divorce law reform, had introduced and succeeded in getting passed. While the medical profession might have hoped that the ability to petition for divorce on grounds other than adultery would diminish the importance of medical testimony on the presence of VD, the Matrimonial Causes Act brought them a new set of problems. Clause 2 (d) of the Act stated:

A petition for divorce may be presented to the High Court either by the husband or the wife on the ground that the respondent...is incurably of unsound mind and has been continuously under care and treatment for a period of at least five years immediately preceding the presentation of the petition.⁶⁰

The clause raised concerns within the BMA CEC that doctors might be put into ethical and legal difficulty for breach of confidence when, prior to any legal proceedings being started, they were asked to state whether or not a patient was incurably insane. This differed from other situations in which a doctor might legitimately give patient information (i.e. in the witness box or during a precognition) because the doctor's opinion was sought in order to determine whether a petition for divorce could be submitted. As legal proceedings were not officially underway at the time of the consultation, the doctor's opinion would not be considered as *prima facie* privileged. In February 1938, the CEC asked the BMA's legal advisers to examine the position. Their response indicated that a breach of confidentiality alone was unlikely to lead to legal action, but if the breach were coupled with an allegation of libel, slander or negligence this would pose more problems. Their advice was that doctors should decline to give an opinion on a case until directed by a court, but that they could allow an independent medical expert to examine relevant records on behalf of the petitioner.

The CEC passed on a copy of these remarks to the BMA's psychological medicine group committee with a suggestion that amending legislation was needed to protect doctors under the Matrimonial Causes Act, and that the two committees might co-operate to discuss the position. The psychological medicine group committee agreed and a joint subcommittee was formed. At their first meeting, they reiterated the

⁶⁰ Matrimonial Causes Act 1937, section 2 clause d).

problem. The doctor was bound by professional secrecy and should only give information at the direction of a court, but the medical opinion was needed for the petition for divorce to be filed which would get legal proceedings underway. Not to give such opinions would amount to obstructing justice. Therefore, the problem was not so much the disclosure as its timing, and the subcommittee agreed with the CEC that the resolution lay in amending legislation 'which, by placing the practitioner under a statutory obligation to provide the required information, would protect him both against the danger of offending ethically and against the danger of incurring serious legal risks.'⁶¹

A letter to the *BMJ* in early March indicated that the London & Counties Medical Protection Society were also concerned about professional secrecy under the Act

A patient is placed under the doctor's care by some person or authority who is responsible for the patient – whether it be a relation or local authority matters little. It may be argued that the doctor is responsible not to the patient but to the person who employs him for the purpose of caring for the patient. In ordinary circumstances presumably a doctor without hesitation would give information regarding the health and prognosis of a patient to a husband or wife. Is, therefore, the extent of the information sought, or the purpose a factor to be considered by a practitioner in giving or withholding information?⁶²

Because mentally ill patients were not deemed competent to give consent, relevant information was normally given to a close relative or guardian. Often this was the spouse of the patient, but in the case of clause 2 d) of the Matrimonial Causes Act, the passing of the information to the spouse might actually be detrimental to the interests of the patient. The person who was supposed to protect the patient's interests could therefore pose a threat to them and the question became: can information that would normally be passed on, be denied on grounds that the guardian may use it against the patient? In discussing this position in April, the joint subcommittee at the BMA again reiterated the belief that amending legislation was necessary including a provision that 'an opinion should be given under Clause 2 d) of the Act only by order of the Master

⁶¹ BMA CEC minutes 1938. Joint subcommittee re: Matrimonial Causes Act

⁶² *BMJ* 12 March 1938. Letter from Richard W Durand, p591.

of Lunacy'⁶³. Indication that the embers of the early interwar debate still glowed was given in the joint subcommittee's acknowledgement that a similar protection was needed under Clause 7 c) which permitted petitioning for divorce on the grounds that a spouse was suffering from a communicable form of VD at the time of marriage.

The joint subcommittee passed on its thoughts as recommendations to the CEC and suggested that the Board of Control should be courted for support. This suggestion was acted upon and Sir Lawrence Brock, secretary of the Board of Control, was consulted. Brock distinguished between the legal and ethical position of doctors under Clause 2 d). He suggested that the ruling in the case of *McEwan v Watson* (discussed below) made clear that the doctor would be legally entitled to give the required information. This did still leave the ethical problem but Brock suggested that as the doctor would be forced to give the information in the witness box during the hearing, it was 'questionable whether he would be protecting the interests of his patient by declining to give it at an earlier stage. In many cases, he would be acting in the interests of his patient in giving his opinion to the prospective petitioner, who would then abandon his or her intention of bringing an action.'⁶⁴ In terms of allowing the Master of Lunacy to determine when information should be divulged, Brock thought there were no legal grounds on which the Master could differentiate between cases and, therefore, the proposal was unwise. In response to Brock's opinions, the joint subcommittee made a specific statement of the fact that it would be unethical for a doctor to give information to a prospective petitioner in the circumstances described under clause 2 d). Thus, they, too, were acknowledging that there could be two separate issues - unethical behaviour and legal liability. In order to get clarification on the legal position, they asked a BMA solicitor to consider the position in the light of the *McEwan v Watson* ruling.

Watson v McEwan was a case that had originated in the Scottish Court of Session, but was taken on appeal all the way to the House of Lords in 1905. The circumstances were as follows. Jessie McEwan was married in 1900. The marriage was not a success and in September 1901 she moved out of the marital home and instructed her lawyer that she was considering petitioning for divorce on grounds of cruelty. With this in mind, she consulted and was examined by Sir Patrick Heron Watson, a very eminent physician, in October 1901. Jessie McEwan petitioned for

⁶³ BMA Joint subcommittee re: Matrimonial Causes Act 25 April 1938.

⁶⁴ Ibid.

divorce in December 1902, on grounds of ill health as a result of cruelty. The proof hearing was started in July 1903 and then adjourned until October. Jessie McEwan did not call Watson to testify. On 20 October 1903, Thomas McEwan's lawyers asked Watson to re-examine Jessie McEwan with a view to giving evidence for Thomas McEwan's defence at the adjourned hearing. Watson agreed to the request and gave evidence on 24 October. He also passed over to Thomas McEwan and his lawyers, without Jessie McEwan's consent and, allegedly, 'in the knowledge that such consent would have been withheld if asked for' the notes he had made at the time of his initial consultation in 1901.⁶⁵ He further alleged, both in the witness box and during his precognition with Thomas McEwan's lawyers, that at the time of the 1901 consultation, Jessie McEwan had been 'bent upon inducing premature labour, so as to free her of any permanent reminder of her marriage with said Thomas McEwan, meaning thereby that the pursuer was desirous criminally to procure abortion.' It was this slur on her character which Jessie McEwan perceived as the reason for the subsequent failure of her divorce petition. Consequently, she brought an action against Watson for damages.

Four charges were laid against Watson. He was accused of breaching medical confidentiality both in the witness box and by giving Thomas McEwan and his lawyers information about Jessie McEwan prior to the divorce hearing. The remaining two charges were for slander connected to his alleging, both prior to and in the witness box, that Jessie McEwan had intended criminally to procure abortion. In the first hearing, the judge – Lord Kincairney – dismissed the charges of breach of confidentiality and slander regarding Watson's testimony in the witness box, on the ground that these were *prima facie* privileged. However, he upheld the two charges relating to the disclosure during the prior conversation with Thomas McEwan and his lawyers, basing his decision largely upon the precedent of *A B v C D*, 1851 (the prenuptial fornication case discussed in chapter 2) that confidentiality was an integral part of the doctor – patient relationship. On appeal, Watson succeeded in having the outstanding charge of slander overturned so that only the charge of breach of confidentiality outside the witness box stood. A further appeal to the House of Lords saw the Lord Chancellor (Halsbury) and the law lords unanimously conclude that this charge should also be disallowed. The main reason for the decision was that, if

⁶⁵ Watson v McEwan, *The Scots Law Times Reports* Vol.12 (Edinburgh, 1905), 249.

statements given to parties in preparation for a trial were not privileged, the process of justice would be made more cumbersome as witnesses would have no opportunity to indicate what testimony they would give in the witness box. While the Lord Chancellor appreciated that his interpretation of the law might lead to some potentially slanderous information being given to a lawyer for a case which never came to trial (and therefore was not privileged), this information would not be publicised and did not, therefore, pose a sufficient threat to justify litigation.

The BMA interpreted this decision as providing a defence for a doctor who was alleged to have broken confidentiality before legal proceedings were officially underway. However, it did not prevent a legal action being brought. Even if such an action was likely to fail, it was nonetheless a burden:

Even if a man is a member of one of these (medical) protection societies he nonetheless has to make a considerable sacrifice in time and money in order to assist the society in getting up the case for his defence, he has to attend on many occasions at the solicitor's office, he has to attend court, and he is of course faced with the worry of such proceedings and the possible adverse effect they may have on his practice or upon his standing in the profession.⁶⁶

These ill effects might be sufficient reasons for someone who felt ill-done by a doctor to seek revenge, even with the knowledge that the case itself was likely to fail. Moreover, it was not always possible to recover costs from such cases, particularly those involving mentally ill patients. In light of this, the argument that there would be a strong defence of privilege in the event of litigation, was insufficient. Doctors either needed separate legislation which protected them from legal proceedings resulting from the giving of information under Clause 2 d) or the legislature should use independent examiners to determine whether or not there was suitable medical evidence for a petition for divorce to be filed.

The BMA was receiving publicity for its dissatisfaction. During a debate at the Medico-Legal Society, Dr J L Moir made reference to the BMA's concern that doctors would not be protected under the Matrimonial Causes Act. At the same meeting, Dr R D Gillespie echoed the feelings of anxiety but stressed that it was not

⁶⁶ BMA CEC Letter from solicitor 12 May 1938.

rooted purely in self-interest: 'they were deterred by a natural loyalty to their patients, apart from any desire to protect themselves.'⁶⁷ Gillespie's comments are significant in highlighting the twin forces of professional ethics and professional self-interest that had been evident in earlier debates over medical confidentiality. Whereas the benefit of medical confidentiality to public health had been stressed in the debates involving VD treatment, under the Matrimonial Causes Act breach of confidentiality only posed a threat to a small class of mentally ill patients. Moreover, the disclosure was made to the spouse, who, as guardian, was normally permitted to receive such confidential information. Gillespie was, therefore, reverting to the ideal of traditional doctor – patient confidentiality in order to maintain a fig-leaf of ethics whilst arguing for protection under the law.

The BMA's discontent was also being discussed in the House of Commons. On 9 May 1938, Alan Herbert, the author of the Matrimonial Causes Act drew attention to the potential defects in his bill which the medical profession had highlighted:

The (BMA) Council has considered the ethical position of the medical man in charge of an insane patient...when approached for an opinion by a prospective petitioner and the legal position of the medical man in the event of a patient whom he has stated to be incurably of unsound mind subsequently recovering. The Council is advised that any opinion expressed by the medical practitioner as to the patient being of unsound mind would not be covered by the protection given under the Mental Treatment Act or the Lunacy Act; that the safest course would be for the practitioner to decline to express any opinion save by the direction of the court....The adoption of this attitude would, however, make the Act unworkable, and the Council feels that the most satisfactory way out of the difficulty would be the introduction of amending legislation.⁶⁸

The *BMJ* continued to carry articles relating to the Act. In June, a report in the medico-legal section suggested that 'as the patients to whom the inquiries relate will

⁶⁷ *BMJ* 7 May 1938, p.1021. Report of Medico-Legal Society debate on medico-legal aspects of the Matrimonial Causes Act (1937), on 28 April 1938.

⁶⁸ *Parliamentary Debates, House of Commons* vol.335, p1361.

almost certainly be certified, it can hardly be said that the confidential relation between doctor and patient exists in such a form as to prevent an officer charged by the law with the detention and care of the patient, from giving information for the purposes of assisting the administration of justice.’⁶⁹ This seemed to imply a two-fold security for doctors. Not only was there a different form of confidential relationship, presumably because there was often a guardian involved as a third party, but, as the breach of secrecy was for the purpose of justice, the doctor’s communication would be privileged. This approach emphasised the principle that the information was given for legal purposes, ignoring the fact that, at the time of communication, legal proceedings were not underway. In this scenario, privilege would effectively be subject to future events i.e. the start of official legal proceedings. However, the article pointed to the fact that none of the cases which the courts had heard thus far had led to legal problems for the doctors involved.

In early June 1938 the President of the Divorce Court, Sir Boyd Merriman, heard a relevant test case in which he ruled that, subject to considerations of public interest, the Board of Control could disclose to any properly constituted guardian ad litem, prior to trial, documents and records in the Board’s possession as it ‘must unquestionably be in the interests of justice.’⁷⁰ Effectively, this ruling permitted lawyers to request the medical records of mentally ill patients from the Board of Control in order to determine whether divorce could be sought under clause 2 d) of the Matrimonial Causes Act. The Board of Control had opposed the petition.

In September, the BMA council met with Brock from the Board of Control. The council stressed that their aim was to get legislation which would assure doctors that legal actions could not be brought against them – a stronger assurance than the idea that they would have a good defence of privilege when cases were brought. They recommended that amending legislation should be along the lines of clause 16 of the Mental Treatment Act 1930 which stressed that a doctor carrying out his duty under the Act would only be liable to any legal proceedings, civil or criminal, if he had acted in bad faith or without reasonable care. Whether these grounds for action had been met was to be determined by the High Court and if they agreed that a case could

⁶⁹ *BMJ* 4 June 1938, p.1237.

⁷⁰ *The Times* 2 June 1938.

be made, the doctor in question had to be notified and given an opportunity to defend himself.⁷¹

While Brock agreed that the Matrimonial Causes Act was open to criticism on the ground that 'it invited the doctor to prophesy,'⁷² he suggested that a resolution may be found in amending the English legislation to bring it in line with the Divorce (Scotland) Act, 1938, 'which makes continuous detention under care and treatment for five years adequate proof of incurability, the onus of proving curability being placed on the respondent.'⁷³ Although not discussed during the meeting, the question of how strict an interpretation should be put on the continuity of treatment over five years – did an occasional weekend out or visit home negate the continuity? - was queried elsewhere.⁷⁴ Brock indicated that while he would recommend the views of the Association to the Minister for 'favourable consideration,' it was unlikely that the government would sponsor an amending bill unless there was clear evidence that the Matrimonial Causes Act had broken down. In light of this, a private members bill was a better prospect. Pressed as to which of the two proposed amendments Brock favoured, he indicated that the main consideration was which would be more successful.

I am not sure, he said, that it would be easier to get the House to adopt the Scottish formula. He added that the argument that it was unfair to expect a doctor to prophesy was one which might commend itself to the House whereas the amendment proposed by the Association might appear on the face of it to be an attempt to increase medical privilege in which case the House would probably be reluctant to support it.⁷⁵

The prospect of a private members bill dealing with medical privilege, only a year after Graham-Little's failed attempt, was not a happy one. Moreover, despite Brock's optimism that the House might be sympathetic to the difficulty of prophesy, elsewhere it was argued that the doctor was only being asked as to the likelihood that

⁷¹ Mental Treatment Act 1930, Section 16 No. 1-3.

⁷² BMA CEC 11 October 1938. Report of meeting between representatives of the BMA and the Board of Control on 26 September 1938.

⁷³ Ibid.

⁷⁴ *BMJ* 31 December 1938, p.1394-6. "Care and Treatment" Under Herbert's Act.

⁷⁵ BMA CEC 11 October 1938. Report of meeting between representatives of the BMA and the Board of Control on 26 September 1938.

a patient would recover to a sufficiently good state of health to be capable of leading a normal married life.⁷⁶ The prospects of getting amending legislation did not seem good.

The problem was put to the Minister of Health in Parliament on 22 November. His response was that 'the Board of Control had suggested to the Mental Hospitals Association that the position of a medical superintendent might be safeguarded if the visiting committee gave him definite instructions to answer reasonable enquiries. The Minister of Health was not, however, empowered to give visiting committees any direction in this matter.'⁷⁷ By the following February, the mental hospitals committee of the London County Council was indicating that the supply of medical reports by the council's medical officers or their appearance as witnesses in court would be 'subject to conditions and payment of fees as the committee may prescribe.'⁷⁸

That collective responsibility seemed to be one resolution to the problem was emphasised in June 1939, when the President of the Probate, Divorce and Admiralty Division (Merriman) complained that while 'all other mental hospitals assisted the courts as much as they could in supplying information on the condition of patients,'⁷⁹ the authority responsible for Warlingham Mental Hospital had failed to do so. The authority in question, Croydon Corporation, issued an early apology and a fortnight later the medical superintendent of Warlingham wrote to the *BMJ* emphasising that he had always complied with the legislation.⁸⁰ While 'after some discussion' the Board of Control and the local authorities had agreed to place relevant patient records at the disposal of the court in order that the petitioner's solicitors could build a case, debates as to the implications for doctors of the Matrimonial Causes Act rumbled on.⁸¹

While the Matrimonial Causes Act 1937 represented a liberalisation of the divorce law in England, this did not ease the position of doctors with regard to giving medical evidence in divorce cases. The major concern was that a professional opinion was being sought before legal proceedings were begun and consequently the doctor's statement was not privileged against litigation. Clearly, doctors' primary concern was to protect their own interests by seeking amending legislation. However, a separate

⁷⁶ *BMJ* 4 June 1938, p. 1237.

⁷⁷ *BMJ* 3 December 1938, p. 1184.

⁷⁸ *BMJ* 25 February 1939, p. 410.

⁷⁹ *BMJ* 3 June 1939, p. 1156.

⁸⁰ *BMJ* 17 June 1939, p. 1268.

⁸¹ See for instance the opinions expressed at the annual meeting of the Mental Hospitals Association on 6 July, as reported in the *BMJ* 22 July 1939, p. 189-90.

ethical concern was raised in so far as the disclosure to a spouse who would use the information to divorce the patient clearly questioned the doctor's position. Was the doctor's duty to assess the ends to which the medical information would be put? In the early interwar years the CEC had been asked a similar question in connection with the issuing of certificates declaring a person to be free from VD. In that instance they had resolved that the purpose was not important. In the case of their mentally ill patients, doctors seem to have decided to follow the interests of the courts in supplying the relevant information once they were satisfied that they could do so with little threat of legal repercussions to themselves.

A Chance pregnancy highlights the ongoing problem of confidentiality in relation to abortion.

The most persistent issue involving medical confidentiality from the late nineteenth century through to the end of the interwar years was the doctor's duty to notify cases of criminal abortion. The coroner's inquiry into the death of Vera Evelyn Norris following an alleged abortion in 1938 demonstrates that the doctor's duty to notify the police was little clearer at the end of the interwar years than it had been at the time of the Royal College of Physicians' consultation with Clarke and Avory in 1896. Norris became pregnant during the summer of 1938, most likely by James Miles Chance. In August, the same month in which she admitted to Chance that she was pregnant, she consulted Annie Christina McAuliffe, a trained nurse and midwife. McAuliffe, the mother of an acquaintance of Norris, later claimed that Norris had consulted her for constipation. However, she suspected that Norris was pregnant and when, in September, she indicated to Norris that giving her enemas for constipation would not cause her to abort, Norris indicated that 'everything would be in order as she had managed three miscarriages before.'⁸² McAuliffe subsequently claimed that she had refused to administer any further treatment. A long-time friend and former lover of Norris's, Bernard Austen Barrington, was also aware of her pregnancy by the end of August. She indicated to him, as she did to Chance, that she wanted an abortion. On 10 October Barrington took her to see, Marguerite Stewart, a female doctor who lived close to his own home. According to Stewart's account of the consultation, Norris gave a false name and address before stating that she was four months pregnant:

⁸² PRO MEPO 3/1030

and did not think it right to bring a child into the world under such circumstances. She had no friends or money. She said she had received treatment to procure an abortion and had received injections into the thigh. She also stated that she had taken thirty grains of quinine each night, and had been syringed with a hot substance by a trained nurse.⁸³

Stewart made an abdominal examination and sent her away with a bottle of medicine. Norris visited McAuliffe again on the afternoon of 12 October, by which time she was complaining of a headache and shivers. McAuliffe claimed that Norris had asked if she knew of a doctor who would perform an abortion but she had refused to give her a name. During the night Norris had a miscarriage in the bathroom of her flat. Chance was with her at the time and the next morning put her in a taxi as 'she said she wanted to round to a nurse friend of hers to be examined about the afterbirth.'⁸⁴ According to McAuliffe, she looked very ill and could not walk very well. Norris asked if she could be nursed at home, but McAuliffe said she could not nurse her until she had returned home and called in a doctor. Norris did go home but did not call a doctor. Barrington called to her flat at 5 p.m. and found her ill in bed. He did not stay as Chance was due to arrive and 'he did not particularly want to meet him.'⁸⁵ Chance arrived at 7 p.m. and immediately called Arnold Harbour, Metropolitan Police surgeon, who, on examination of her, advised her immediate removal to hospital. Norris was admitted to St Mary Abbots Hospital at 12.40 a.m. on 14 October, where the assistant medical officer, Llewellyn Edwards assessed her condition as 'very poor...signs of a recent miscarriage were present.'⁸⁶ Norris died the following morning at 10 a.m.

A police investigation provided no conclusive evidence that Nurse McAuliffe had performed the abortion that led to Norris's death. At the coroner's inquest, Mr Oddie (the coroner) stated that there was little doubt that this was in fact what had happened and 'it is most unfortunate that Dr Harbour or the hospital authorities did not inform us before Ms Norris died.'⁸⁷ However, he stressed that he did not blame

⁸³ Ibid.

⁸⁴ Ibid.

⁸⁵ Ibid.

⁸⁶ Ibid.

⁸⁷ Ibid.

Harbour and acknowledged the dispute between the legal and medical professions about the doctor's duty in such circumstances.

While admitting that there is a moral obligation on the part of the doctor to preserve confidential relations between him and his patients, there are certain circumstances in which that confidence should be over-ridden by the duty, in the interests of justice, to inform the authorities of the committing of a crime. The position ought to be considered by the authorities as to what a doctor should do in these particular circumstances. It is important to protect the public against these crimes which so often lead to death.⁸⁸

In light of the primary interest in detecting the abortionist, it is particularly significant that Harbour was a Metropolitan Police divisional surgeon. Despite his connection to the police, he did not inform them after he was called in to see Norris. Harbour concluded his statement to the police with the following: 'I consulted my solicitors the following morning and they advised, or in fact instructed me not to communicate with the police.' This clearly emphasises the confusion on the issue. Even a police doctor was unsure of his position in cases of abortion and his solicitors instructed him *not* to communicate information to the police. With such precedents, it is little wonder that the notification of cases of illegal abortion continued to prove a very grey area for the medical profession.

Conclusion

The foregoing examples add to the list of questions involving medical confidentiality in the interwar period. They demonstrate the wide range of subjects which prompted such questions, from medical secrecy at sea to confidentiality in relation to mental patients. The examples demonstrate the persistence of medical confidentiality as an issue. Only a year after Graham-Little's failure to get his private members bill to the committee stage, the BMA council were contemplating another attempt at a private members' bill, this time in connection with medical privilege under the Matrimonial Causes Act. Moreover, each case illustrates the different nuances of the debate over the boundaries of confidentiality which made it so difficult for the CEC in the early

⁸⁸ Ibid.

interwar years, or for Graham-Little later in the period, to draw up clearly defined and comprehensive guidelines for doctors.

Chapter 9 – Conclusion

Having taken a chronological approach in the body of the thesis, it is worth pausing in the conclusion to draw out some of the key points and recurrent themes.

People

It is clear that the debate over medical confidentiality involved some very influential figures. From the imposing legal reputation of Lord Mansfield in the eighteenth century through to the Law Officers of the Crown in the early interwar years, some of the keenest legal minds were engaged in delineating the boundaries of medical confidentiality. Similarly, challenges to the law came from the most senior figures at the Ministry of Health and the BMA. Of the many individuals involved, two stand out: Birkenhead and Addison. As figureheads of their respective sides at the highpoint of the debate in the early interwar years, they played a significant role in determining the outcome of the confrontation over medical privilege.

Birkenhead was instrumental in fending off the Ministry of Health and BMA in their drive for medical privilege and his influence continued to be felt at the time of Graham-Little's private members' bill in 1927. While Birkenhead was evidently not in favour of a change in the law from the outset, the political uncertainty of the coalition government at the end of the War, including the position of Addison in the Ministry of Health and the change in Lord Chief Justice, gave him a measure of breathing space to build his case against the Ministry's proposals. The publication of his views in 'Should a doctor tell?' represented a clear warning of the difficulties which future advocates of privilege would face. The BMA central ethical committee, no doubt tired of re-considering the issue by 1922, were clearly further demoralised by his strong refutation of the grounds for medical privilege. When the Ministry were approached in an attempt to gain their support for legislation in the late 1920s, they too pointed to Birkenhead's essay as a strong reason not to get too prominently involved. Yet, for all Birkenhead's skill in defending the legal position, the fact that he was defending the status quo made his task considerably easier. His ability to point to 150 years of case law which supported his position (although in at least one case judicial comment had been edited to suit his purpose), placed the onus on supporters of privilege to justify the overturning of precedent. This, as became

evident, was a highly complex task owing to the varied and wide-ranging circumstances in which confidentiality could be invoked or breached.

Addison's decision to take the problem straight to the Lord Chancellor and ask for his support in changing the law is difficult to construe as anything other than naïve. Perhaps Addison overestimated his influence within the coalition government or simply believed that Birkenhead would appreciate the fundamental importance of confidentiality in combating VD. Either way, there was little likelihood of the law endorsing a measure that would remove a level of medical testimony from the courts at a time when a rise in divorce petitions meant the testimony of VD doctors was in high demand. It is feasible that a concerted effort to stir-up public opinion in favour of protecting the confidentiality of VD schemes would have provided greater leverage with which to challenge the law. However, as the head of a new Ministry with a tough agenda in the immediate aftermath of the First World War, confidentiality was only one of many concerns.

Issues

One of the key problems for proponents of medical privilege was the great range of issues and variety of circumstances in which questions of confidentiality could be raised. The BMA central ethical committee's belief that the specificity of each case meant that no general rules could be laid down is a sentiment echoed in modern writings on confidentiality.¹ Graham-Little's second private members bill on medical privilege demonstrated the knots into which proponents of privilege could tie themselves whilst trying to demarcate firmly the boundaries of what would and would not be covered by the legislation. While the range of issues is fundamental to understanding the complexity of legislating on medical confidentiality, it is clear that certain subjects received more attention than others - in particular, VD and abortion. It is not difficult to see modern day parallels to these in debates over HIV/AIDS or the concerns over confidential abortions given to girls under the age of 16. In part, the continued interest in these subjects can be explained by the reflection of Mason and McCall Smith that 'sexuality is so integral a part of human nature that its influence pervades the doctor's surgery.'² But, the social circumstances of the early twentieth century exacerbated the fact. State interest in tackling the public health

¹ Mason and McCall Smith, *Law and Medical Ethics* 4th ed. (London, 1994), 171.

² Ibid. 29.

problem of VD became entangled with judicial concerns in administering efficiently the public justice system. Individual divorce cases became battlegrounds in which competing ideals of public interest were contested, in which ministerial regulations were set against judicial authority and in which traditional professional ethics were confronted by established legal precedent. A similar situation emerged in relation to abortion. Legal inquiries into post-abortion deaths questioned the doctor's role in society. In the eyes of the law, the doctor's primary duty was to society, while for private medical practitioners the traditional obligation of confidentiality prevented them becoming an additional arm of the law.

Comparisons

Two analogies recurred time and again during the debates: the privilege of the lawyer - client in the preparation and execution of legal proceedings and the privilege customarily recognised between clergymen and those who turn to them for spiritual advice. Neither has a basis in statute law and the former has a more sure foundation in precedent than the latter. Although at some points argument was made that doctors sought a similar privilege to that given to lawyers as a matter of professional equivalence and status, in general, the analogy was drawn to question whether the justification for the lawyer - client privilege was not equally applicable to the doctor - patient relationship. The law pointed to the fact that the privilege was the client's and not the lawyer's, but this refuted only those doctors concerned with privilege as a badge of status. Lawyers and doctors both claimed a level of expertise which the public needed liberty to access without underlying concerns that the consultation might be used against them at a later date. The English legal system had evolved in a way which acknowledged the public interest in legal privilege. By contrast, the precedent excluding medical privilege dated from the late eighteenth century when medicine operated solely in a private market, meaning that no equivalent argument could be made for public health.

The comparison with the privilege given to clergymen was connected more to duty than consequence. The advocates of medical martyrdom wished to portray doctors as members of an honourable profession, bound by a long tradition of ethics, including an obligation to maintain their patients' confidentiality. Such a position was impossible for them to maintain. While the clergyman's silence was absolute, the doctor's was more of an optional mute. Even the hallowed text of the Hippocratic

Oath was easily interpreted as permitting disclosure: ‘anything which I see in the course of my profession *which ought not to be spoken of abroad* I will not disclose’. More significantly, the doctor’s ethical position was entangled with self-interest. From Caesar Hawkins in 1776 to Bayly in the aftermath of *Needham v Needham*, it was apparent that stressing the importance of confidentiality was a good advertisement in a competitive medical marketplace. Moreover, the dictates of professional ethics did not prevent a doctor breaching confidentiality to protect himself or a colleague during litigation.

The other set of frequently used comparisons were those between English law and that of other countries. Despite their separate legal systems, England and Scotland held essentially the same position on medical confidentiality. There were occasional misinterpretations of Scottish legal precedent as endorsing a measure of medical privilege. This was factually inaccurate as the two major cases in point (*AB v CD*, 1851 and the three stages of *McEwan v Watson*, 1904-5) only went so far as to recognise an implicit contract of confidentiality in the doctor – patient relationship which could be broken either in the witness box or during a precognition. Both sides of the debate over privilege looked to international law for precedents which supported their position. While many European countries had measures of medical privilege written into their penal codes, it was to New Zealand that the Ministry of Health turned to illustrate the legislation which they thought was necessary in the early interwar years. This would be an interesting point to examine further as New Zealand was strongly connected to the UK via the Commonwealth. It became a self-governing dominion in 1907 and passed the law which the Ministry sought to emulate in 1908. The scope and funding of the present thesis has not allowed any further examination of this point. However, it is suggested as an area requiring more work. While the influence of British writing and legislation on medical confidentiality extended beyond its shores, international law seems to have had very little practical impact upon the system in Britain during the period of study.

Objectives

The debate over medical confidentiality encapsulated a multitude of objectives. Although at times there was an explicit citing of specific aims, at others it seems that the dividing line between motivations was not easily drawn. It is clear that throughout the whole period, confidentiality was a key element in the medical

profession's sense of identity. Ethics was a key way of delineating the profession from the quack or unregistered doctor, and confidentiality was an issue that had long been prominent in codes of ethics. The citations of the Hippocratic Oath in the *BMJ* in the early interwar years is a clear example of the medical profession not only promoting its sense of a long-standing tradition of ethical practice, but also using that to promote itself as an established profession.

There were times in the debate where the boundaries of ethics and self-interest were dubious. Having examined in detail the circumstances surrounding Hawkins' plea for privilege in the Duchess of Kingston's trial it is difficult not to see self-interest as a central motivating factor. His desire to protect his elevated status within the profession and society, complete with its associated trappings, by advertising his belief in the sanctity of confidentiality to a packed House of Lords is a crucial omission from all subsequent citations of Mansfield's ruling as precedent. That ethics could be used as a means of advertising to patients, even without the inconvenience of appearing in the witness box, was a point picked up in the interwar years by Dr Baley of Harley Street. Using the media attention given to the issue in the aftermath of *Needham v Needham*, Baley announced to newspaper readers that *he* would never breach patient confidentiality, even if it meant going to prison. Given the restrictions on advertising in the medical marketplace at the time, such comments were an acknowledged means to promote one's interests in a seemingly ethical way.

The relative weight of money and morals in defining who had access to patient information was also challenged by the changing circumstances of medical employment. By the interwar years the advent of partially state-funded employment under national insurance presented new questions about the doctor's obligation. Only occasionally, as in the case of VD treatment, did the interests of the state correspond with the tradition of confidentiality between doctor and patient. More often doctors had to weigh up the potential benefits to public health of breaking confidentiality e.g. their endorsement of notification of infectious disease and their unwillingness to see notification of criminal abortion as an absolute duty. Money had a role to play in all these areas. The state paid fees for notification of births and levied fines on doctors who failed to notify infectious disease. While the amounts of money involved were small,—they were not without significance for doctors. At the BMA's annual representatives' meeting in Newcastle in 1921, the representative body passed a resolution demanding that the council 'continue to press for the restoration of the 2s.

6d. notification fee forthwith and without delay.’³ While National Insurance brought state contribution to the provision of health, doctors were still far from being state employees. Relative financial independence from the state allowed them greater license to oppose collective measures with which they disagreed and private employment still placed the emphasis on the traditional obligation to the patient. This latter point, as the oft-repeated quandary of the syphilitic fiancée made clear, was not without its own problems.

Allegations that doctors wanted privilege for reasons of status, while not without foundation, were not accurate for the majority of those involved in the question at either the Ministry of Health or the BMA. The Ministry’s agenda was clearly connected to their responsibility for public health. In light of this, the Ministry was usually interested in doctors breaking confidentiality to notify births, abortions or infectious disease. VD provided an exceptional circumstance in which medical privilege was aligned with the Ministry’s policy on public health. The implications of the spread of VD for the health of a population recovering and rebuilding after war were significant, and the fundamental importance of confidentiality in combating the problem was at the heart of the Ministry’s support for privilege.

The BMA’s role in protecting the interests of its members was complicated when doctors could be engaged in different forms of medical practice. Clearly, traditional concepts of ethics and the ideal of the doctor as an honourable individual drove the BMA to defend staunchly legal encroachment into medical confidentiality in 1914-15. However, an examination of the practicalities of obtaining a change in the law led to a split between the representative body and the BMA council. The compromise of the resolutions passed at the annual representatives’ meeting in 1922, suggested that while the BMA was still ready to challenge the law on medical privilege, the more conservative minds of the CEC and council would decide when BMA resources would be given in support of the cause.

The judiciary’s main concern was the provision of an efficient justice system. Medical evidence was very useful in this regard, and, consequently, the law officers were reluctant to encourage any measures which would curb their ability to demand such ~~e~~vidence in court. This was exacerbated in the interwar years by the escalation

³ BMA minutes of ARM, 1921 (Newcastle) – Min 285.

in the number of petitions for divorce in which the evidence of VD doctors could be crucial. Nonetheless, while the key members of the judiciary remained staunchly opposed to medical privilege, there were some legal voices expressing support for the cause. The legal journals and the debates at the medico-legal society revealed that legal opinion was not wholly blinded to the importance of medical confidentiality, but in court it was always regarded as a subsidiary interest to the law.

Class

While theoretically doctor – patient confidentiality was a principle unaffected by class considerations, it is possible to identify class issues at key points of the debate. Social standing was integral to the whole of the Duchess of Kingston's trial, from its taking place in the House of Lords to the large upper class audience it attracted. Social standing was also important to an understanding of the pleas for privilege from witnesses, including Caesar Hawkins whose plea for privilege was a display aimed at protecting and promoting his image as an honourable gentleman.

As Barbara Brookes has made clear, social class was an important factor in determining attitudes to abortion and McLaren's assessment of *Kitson v Playfair* emphasises the point. The success of Linda Kitson in portraying herself as a wronged middle-class woman was central to the verdict against her brother-in-law. In McLaren's words 'class played a key role in colouring nineteenth-century notions of confidentiality'⁴. This was more than a recognition that the press and public opinion would be more likely to defend the honour of a middle-class lady, but an acknowledgement that the lower classes would struggle for the funds to mount legal proceedings.

Morrice notes the concern of private practitioners, and particularly the medical elite, that they could be forced to breach not only their professional honour but the honour of their patients in having to give evidence about their 'sexual misdemeanours' resulting in abortion or VD: 'for Dawson the threat to the social fabric through the avoidance of medical advice or the exposure of sordid secrets among the upper classes was prominent...he wished to keep the elite out of the cruel glare of public exposure'⁵. However, the cases which caused such difficulty in the interwar years tended to involve patients who had been treated at the government

⁴ A McLaren, 'Privileged Communications', 141.

⁵ A Morrice, 'Should the doctor tell?', 74.

sponsored VD treatment schemes. Unlikely to be upper class patients, this rise in profile of secrecy in connection with patients from the lower classes reflected both the development of public funded treatment for VD, and changes in the divorce law which opened up the courts to the less wealthy. Thus, while the key cases of the eighteenth and the nineteenth century had involved middle and upper class patients, the twentieth century cases involved the lower classes. This change reflected the growth of state interest in health. The poor who had access to public VD treatment centres also had greater access to the divorce courts.

Other state sponsored schemes discriminated the level of medical confidentiality on the basis of class. The Ministry's medical record card system for national insurance patients was seen as a threat to the confidentiality of working class patients alone. The notification of infectious disease was unnecessary if the patient could be isolated within his or her own accommodation – a measure intrinsically biased towards the more spacious dwellings of the middle and upper classes. A similar position was evident at sea, where passengers with their own cabin could be isolated with greater ease. Moreover, in the eyes of some ship surgeons at least, if a passenger paid for treatment then their position as a private patient removed them from the gaze of the shipping company's medical records – except in serious cases. Therefore, while class was theoretically not a factor in medical confidentiality, in practice its influence was evident.

Gender

With the topics of abortion and VD so central to the debate it is no surprise that questions of gender-bias arise in connection with medical confidentiality. McLaren leaves no doubt that gender played an important role in Linda Kitson's success:

the public was willing in the case of this pretty, persecuted woman to believe in the possibility of a sixteen month pregnancy. Claiming all the while that in her 'lightheaded' way she did not know what she was doing, Linda Kitson, in perfectly portraying the role of the female martyr, got away with adultery, perhaps abortion, and £12,000 as well.⁶

⁶ A McLaren, 'Privileged Communications', 146.

While the law made all criminal abortions notifiable thereby seeming to diminish the level of confidentiality given to women, in practice the medical profession were reluctant to notify unless it appeared the woman in question was dying. In part, this can be attributed to fear of legal repercussions if the allegation proved false – the large damages imposed on Playfair would have preyed on practitioners' minds. However, there is clear evidence of doctors' beliefs that fear of notification would keep injured women from seeking medical assistance, and they strongly resisted the attempts by the judiciary to turn them into private detectives for the law.

The combination of VD and divorce provides an obvious pointer towards gender discrimination. The VD element was also inherently tied-in with class issues. Measures to tackle VD which included any form of compulsion, either in notification or treatment, were seen as targeting the lower classes of society, in particular, female prostitutes. In the upper-classes the perception was that (predominantly male) doctors were not likely to inform a married woman that she suffered from VD 'because to do so would reveal that her husband or husband-to-be had been unfaithful.'⁷ In light of the divided response to Hempson's example of the syphilitic fiancée at the 1920 BMA annual representatives' meeting, it is clear that doctors were not of one mind on the issue. Although there was a disparity in the divorce law at the time of the high profile cases of *Garner v Garner* (1920) and *Needham v Needham* (1921), it is not clear that gender played any significant role in determining the doctor's reluctance to give evidence in either case. There were clear agendas put forward – the impact on public health from a loss of faith in the secrecy of treatment centres and the dishonour to the profession for seeming to have engaged patients on a false premise. The strength of opinion on the latter question led some doctors at the clinics to threaten resignation. Beyond this, medical testimony on VD was required by both men and women as proof of adultery. In *Garner v Garner*, the wife sought proof of her own VD to demonstrate that her husband had infected her. In *Needham v Needham* it was the husband who wanted evidence that his wife had suffered from VD contracted during an adulterous relationship. In both instances, the medical officers called to testify made clear their reluctance to give information because of their belief in the strength of the government pledge of confidential treatment. As examination of the cases shows, the doctor's protest against breaching confidentiality

⁷ Ibid. 145.

was more strongly put in the case where the husband wanted evidence against his wife. VD was a gendered issue and the disparity in the divorce law did not aid the situation. However, the use to which VD doctors were put in proving adultery would have kept the fundamental problem at the fore, even if the sexes had been on an equal footing. For these reasons, it is less likely that gender was of primary concern to the public health doctors who sought privilege in the high profile cases that triggered debate in the early interwar years.

General Conclusion

As a period in which the government, the judiciary and the medical profession were all engaged in the debate, the interwar years were a key stage in the evolution of medical confidentiality in Britain. The rise of state interest in the health of the population, the law's increased demand for medical information and the changing form of medical employment, presented unprecedented challenges to the medical profession's traditional concept of medical confidentiality. As such, it forced doctors to assess the relative weight of their duty to the state, the law, public health and the individual patient. While this represented a considerable change from the context in which Caesar Hawkins had practised medicine in the late eighteenth century, the precedent which he had played an important role in setting was still very much in force. In this way, the action of one doctor, in attempting to protect his elevated status in eighteenth century society, came to bind the whole of an evolving medical profession on the issue of medical confidentiality.

Bibliography

- Aitchison Robertson, W G, *Medical Conduct and Practice. A Guide to the Ethics of Medicine*, (London, 1921).
- Baker, R, 'The History of Medical Ethics', in W F Bynum and R Porter (eds.), *The Companion Encyclopedia of the History of Medicine*, (London, 1993), 852-887.
- Baker, R (ed), *The Codification of Medical Morality* vol.2, (Dordrecht, 1995).
- Baker, R, Porter, D, Porter R (eds.), *The Codification of Medical Morality* vol.1, (Dordrecht, 1993).
- Bartrip, P, *Mirror of Medicine. A History of the British Medical Journal*, (Oxford, 1990).
- Bartrip, P, 'An Introduction to Jukes Styrap's A Code of Medical Ethics (1878)', in R Baker (ed), *The Codification of Medical Morality* vol.2, (Dordrecht, 1995).
- Bartrip, P, *Themselves Writ Large. The British Medical Association 1832-1966*, (London, 1996).
- Beauchamp, T, 'Common sense and virtue in the Scottish moralists', in R Baker, D Porter, R Porter (eds.), *The Codification of Medical Morality* vol.1, (Dordrecht, 1993), 99-121.
- Bernard Shaw, G, 'The doctor's dilemma', in *The Complete Plays of Bernard Shaw*, (London), 503-546.
- Berridge, V, 'Public or Policy Understanding of History?', in *Social History of Medicine*, 16, (2003), 511-523.
- Birch, A H, *The British System of Government* 9th edition, (London, 1993).
- Birkenhead, The First Earl of 'Should a doctor tell?', in *Points of View*, (London, 1922), 33-76.
- Birkenhead, The Second Earl of, *The Life of F E Smith, First Earl of Birkenhead*, (London, 1959).
- British Medical Association Ethics Department, *Medical Ethics Today. The BMA's Handbook of Ethics and Law* 2nd ed. (London, 2004).
- Brookes, B, *Abortion in England, 1900-1967*, (London, 1988).
- Brown, B C, *Elizabeth Chudleigh, Duchess of Kingston*, (London, 1927).
- Brown, I J and Gannon, P, 'Confidentiality and the Human Genome Project: A Prophecy for Conflict?', in S A M McLean (ed), *Contemporary Issues in Law, Medicine and Ethics*, (Dartmouth, 1996).

Burke, J B, *Anecdotes of the Aristocracy*, (London, 1849).

Burnett, J, *A Treatise on Various Branches of the Criminal Law of Scotland* (Edinburgh, 1811).

Burns, C, 'Reciprocity in the Development of Anglo-American Medical Ethics, 1765-1865', in R Baker (ed), *The Codification of Medical Morality* vol.2, (Dordrecht, 1995).

Campbell, A, Charlesworth, M, Gillett, G & Jones, G, *Medical Ethics*, 2nd ed., (Oxford, 1997).

Chervenak, F A & McCullough, L B, 'The Moral Foundation of Medical Leadership: The Professional Virtues of the Physician as Fiduciary of the Patient', in *American Journal of Obstetrics and Gynecology*, 184, (2001), 875-880.

Clegg, H A, 'Professional Ethics', in M Davidson (ed), *Medical Ethics. A Guide to Students and Practitioners*, (London, 1957), 44.

Cohen, J M & Cohen M J, *The Penguin Dictionary of Quotations*, (Harmondsworth, 1960).

Crawford, C, 'Medicine and the Law', in W F Bynum & R Porter (eds.), *Companion Encyclopedia of the History of Medicine*, (London, 1993).

Cronin, A J, *The Citadel*, (Reading, 1996).

Crookshank, F G, *Professional Secrecy*, (London, 1922).

Crowther M A & White, B, *On Soul and Conscience. The Medical Expert and Crime* (Aberdeen, 1988).

Crowther, M A, 'Forensic Medicine and Medical Ethics in Nineteenth-Century Britain', in R.Baker (ed.), *The Codification of Medical Morality* vol.2, (Dordrecht, 1995), 173-190.

Davidson, R, *Dangerous liaisons. A Social History of Venereal Disease in Twentieth-Century Scotland*, (Amsterdam, 2000).

Dickson, W G, *A Treatise on the Law of Evidence in Scotland* vol.2, (Edinburgh, 1855).

Donzelot, J, *The Policing of Families*, (London, 1979).

Downie, R S (ed), *Medical Ethics*, (Aldershot, 1996).

Editor of the *Lancet* and expert collaborators, *The Conduct of Medical Practice*, (London, 1928).

Elder, A V, *Ship Surgeon's Handbook* 3rd edition, (London, 1927).

Elwood, M, *The Bigamous Duchess. A Romantic Biography of Elizabeth Chudleigh, Duchess of Kingston*, (New York, 1960).

Ewing, K D & Gearty C A, *The Struggle for Civil Liberties*, (Oxford, 2000).

Farmer, L, 'Debatable Land: An Essay on the Relationship Between English and Scottish Criminal Law', *Edinburgh Law Review*, 3, (1999), 32-56.

Farmer, L, 'Notable Trials and the Criminal Law in Scotland and England, 1750-1950', in Ph Chassaigne & J-P Genet (eds.), *Droit et Societe en France et Grande Bretagne (12-20 siecles). Foctiones, Usages et Representations*, (Paris, 2003), 143-170.

Fissell, M E, 'Innocent and Honourable Bribes: Medical Manners in Eighteenth-Century Britain', in R Baker, D Porter & R Porter (eds.), *The Codification of Medical Morality* vol.1, (Dordrecht, 1993), 19-45.

Foote, S, *A Trip to Calais. A Comedy in Three Acts*, (London, 1778).

Frevert, U, *Men of Honour. A Social and Cultural History of the Duel*, (Cambridge, 1995).

Gervat, C, *Elizabeth. The Scandalous Life of the Duchess of Kingston*, (London, 2003).

Geyer-Kordesch, J, 'Unnatural Law and Medical Ethics in the Eighteenth Centuryl', in R Baker, D Porter & R Porter (eds.), *The Codification of Medical Morality*, (Kluwer, 1993), 123-139.

Gillon, R, *Philosophical Medical Ethics*, (Chichester, 1996).

Glaister, J, 'Medico-legal Risks Encountered by Medical Practitioners in the Practice of their Profession', reprinted from the *Glasgow Medical Journal*, (September, 1886).

Glaister, J, *Glaister's Medical Jurisprudence and Toxicology*. 2nd edition, (Edinburgh, 1910) - 6th edition (Edinburgh, 1938).

Haakonsen, L, *Medicine and Morals in the Enlightenment: John Gregory, Thomas Percival and Benjamin Rush*, (Amsterdam, 1997).

Hargrave, F, *A Complete Collection of State Trials* vol.11, (London, 1781).

Harris, J, *Legal Philosophies* 2nd edition, (Edinburgh, 1997).

Heuston, R V F, 'Lord Birkenhead', in *Lives of the Lord Chancellors 1885-1940*, (Oxford, 1964).

Hibbert, C, *George III. A Personal History*, (London, 1998).

Honigsbaum, F, 'Christopher Addison: A Realist in Pursuit of Dreams', in D Porter & R Porter (eds.), *Doctors, Politics and Society: Historical Essays*, (Amsterdam, 1993).

Howell, T B, *A Complete Collection of State Trials and Proceedings for High Treason and Other Crimes and Misdemeanours from the Earliest Period to 1783*, (London, 1816).

Hume, D, *Commentaries on the Law of Scotland Respecting Crimes* 2nd edition, vol.2., (Edinburgh, 1819).

Huxley, A, *On the Margin. Notes and Essays*, (London, 1923).

Huxley, A, *Do What You Will Essays*, (London, 1929).

Huxley, A, *Brave New World* (London, 1994).

Hyde, H M, *Lord Reading*, (New York, 1967).

Ibsen, H, 'Ghosts', in *Ibsen Plays: One*, (London, 1980).

Jenkinson, J, *Scotland's Health 1919-1948*, (Bern, 2002).

Jewson, N D, 'Medical Knowledge and the Patronage System in Eighteenth Century England', *Sociology*, 13, (1974).

Jones, G, *Social Hygiene in Twentieth Century Britain*, (London, 1986).

Keown, J, *Abortion, Doctors and the Law*, (Cambridge, 1988).

Kiernan, V G, *The Duel in European History. Honour and the Reign of the Aristocracy*, (Oxford, 1988).

Kitchin, D Harcourt, *Legal Problems in Medical Practice*, (London, 1936).

Kitchin, D Harcourt, *Law for the Medical Practitioner*, (London, 1941).

Lacey, R, *A Dictionary of Philosophy*, (London, 1996).

Lawrence, C, 'Incommunicable Knowledge: Science, Technology and the Clinical Art in Britain 1850-1914', in *Journal of Contemporary History*, vol.20, (1985), 503-520.

Lawrence, C, *Medicine in the Making of Modern Britain 1700-1920*, (London, 1994).

Leslie, D, *The Incredible Duchess: The Life and Times of Elizabeth Chudleigh*, (London, 1974).

- Lewis, J, 'Medicine, Politics and the State', in I Loudon (ed), *Western Medicine. An Illustrated History* (Oxford, 1997).
- Maehle, A H, 'Protecting Patient Privacy or Serving Public Interests? Challenges to Medical Confidentiality in Imperial Germany', *Social History of Medicine*, 16, (2003), 383-401.
- Manchester, A H, *A Modern Legal History of England and Wales, 1750-1950*, (London, 1980).
- Mason, J, & McCall Smith, A, *Law and Medical Ethics* 4th edition, (London, 1994).
- McCullough, L B, 'Virtues, Etiquette and Anglo-American Medical Ethics in the Eighteenth and Nineteenth Centuries', in E Shelp (ed), *Virtue and Medicine*, (1985).
- McCullough L B, 'John Gregory's Medical Ethics and Humean Sympathy', in R Baker, D Porter & R Porter (eds.), *The Codification of Medical Morality* vol.1, (Dordrecht, 1993), 145-160.
- McCullough, L B, 'John Gregory (1724-1773) and the Invention of Professional Relationships in Medicine', *Journal of Clinical Ethics*, 8, (1997), 11-21.
- McCullough, L B, *John Gregory and the Invention of Professional Medical Ethics and the Profession of Medicine*, (Dordrecht, 1998).
- McCullough, L B, *John Gregory's Writing's on Medical Ethics and Philosophy of Medicine*, (Dordrecht, 1998).
- McCullough, L B, 'Laying Medicine Open: Understanding Major Turning Points in the History of Medical Ethics', *Kennedy Institute of Ethics Journal*, 9, (1999), 7-23.
- McHale, J V, *Medical Confidentiality and Legal Privilege*, (London, 1993).
- McLaren, A, 'Privileged Communications: Medical Confidentiality in late Victorian Britain', in *Medical History*, vol.37, (1993), 129-147.
- Melville, L, *Notable British Trial Series*, (Edinburgh, 1996).
- Meyer, G S, 'Criminal Punishment for the Transmission of Sexually Transmitted Diseases: Lessons from Syphilis', *Bulletin of the History of Medicine*, 65, (1991), 549-564.
- Mooney, G, 'Public Health Versus Private Practice: The Contested Development of Infectious Disease Notification in Late Nineteenth Century Britain', *Bulletin of the History of Medicine*, (1999).
- Morgan, K, *Consensus and Disunity. The Lloyd George Coalition Government 1918-1922*, (Oxford, 1979).

- Morgan, K & Morgan, J, *Portrait of a Progressive. The Political Career of Christopher, Viscount Addison*, (Oxford, 1980).
- Morrice, A, 'Honour and Interests: Medical Ethics in Britain and the Work of the British Medical Association's Central Ethical Committee, 1902-1939', (MD thesis, University of London, 1999).
- Morrice, A, '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*, (London, 2002).
- Morrice, A, 'Honour and Interests: Medical Ethics and the British Medical Association', in A H Maehle & J Geyer-Kordesch (eds.), *Historical and Philosophical Perspectives on Biomedical Ethics*, (Aldershot, 2002).
- Newman, G, *Annual Report of the Chief Medical Officer 1919-1920*, (London, 1920).
- Newman, G, *Recent Advances in Medical Education in England*, (London, 1923).
- Oldham, J, *The Mansfield Manuscripts and the Growth of English Law in the Eighteenth Century*, vols. 1 & 2, (London, 1992).
- Orwell, G, *Nineteen Eighty-Four*, (London, 1989).
- Osborn, J L, *Lainston and Elizabeth Chudleigh*, (Winchester, 1915).
- Paris, J A & Fonblanque, J S M, *Medical Jurisprudence*, (London, 1823).
- Pelham, C, *The Chronicles of Crime; or, The Newgate Calendar* vol.1, (London, 1845).
- Phillips, R, *Putting Asunder. A History of Divorce in Western Society*, (Cambridge, 1988).
- Pickstone, J, 'Thomas Percival and the Production of Medical Ethics', in R Baker, D Porter & R Porter (eds.), *The Codification of Medical Morality* vol.1 (Dordrecht, 1993), 161-178.
- Porter, R, 'William Hunter: a Surgeon and a Gentleman', in *William Hunter and the Eighteenth Century Medical World*, (London, 1985).
- Porter, R, 'Lay Medical Knowledge in the Eighteenth Century: the Evidence of the Gentleman's Magazine', *Medical History*, 29, (1985), 138-168.
- Porter, R, 'Plutus or Hygeia? Thomas Beddoes and the Crisis of Medical Ethics in Britain at the Turn of the Nineteenth Century', in R Baker, D Porter & R Porter (eds.), *The Codification of Medical Morality* vol.1, (Dordrecht, 1993), 73-91.
- Porter, R, *The Greatest Benefit to Mankind* (London, 1997).

Reading, The Second Marquess of, *Rufus Isaacs. First Marquess of Reading*, (London, 1945).

Rowland, P, *Lloyd George*, (London, 1975).

Saundby, R, *Medical Ethics: A Guide to Professional Conduct*, (London, 1902 & 1907).

Savage, G, 'The Wilful Communication of a Loathsome Disease: Marital Conflict and Venereal Disease in Victorian England', in *Victorian Studies*, vol.35, (1990).

Searle, G, *Eugenics and Politics in Britain, 1900-1914*, (Leyden, 1976).

Shortt, S E D, 'Physicians, Science and Status: Issue in the Professionalization of Anglo-American Medicine in the Nineteenth Century', *Medical History*, 27, (1983), 51-68.

Smith, J G, *An Analysis of Medical Evidence: Comprising Directions for Practitioners, in View of Becoming Witnesses in Courts of Justice and an Appendix of Professional Testimony*, (London, 1825).

Smith, R G, 'The Development of Ethical Guidance for Medical Practitioners by the General Medical Council', *Medical History*, 37, (1993), 56-67.

Smith, R G, 'Legal Precedent and Medical Ethics: Some Problems Encountered by the General Medical Council in Relying Upon Precedent When Declaring Acceptable Standards of Professional Conduct', in R Baker (ed), *The Codification of Medical Morality* vol.2, (Dordrecht, 1995).

Styrup, J, 'A Code of Medical Ethics', in R Baker (ed), *The Codification of Medical Morality* vol.2, (Dordrecht, 1995).

Tait, G A, *A Treatise on the Law of Evidence in Scotland* 3rd edition, (Edinburgh, 1834).

Tansey, E M, 'From the Germ Theory to 1945' in I Loudon (ed), *Western Medicine. An Illustrated History*, (Oxford, 1997).

Teigen, P H, 'A Kind of Useful Mentor : Applying the History of Medicine to Public Policy', in *Journal of the History of Medicine*, vol.54, (July,1999).

Thane, P, *Foundations of the Welfare State*, 2nd edition, (Harlow, 1996).

Thomson, A T, *Lecture, Introductory to the Course of Medical Jurisprudence, Delivered in the University of London, on Friday January 7th 1831*, (London, 1831).

Trohler, U, 'Human Research: From Ethos to Law, From National to International Regulations' in A H Maehle & J Geyer-Kordesch (eds.), *Historical and*

Philosophical Perspectives on Biomedical Ethics. From Paternalism to Autonomy? (Aldershot, 2002).

Waddington, I, 'The Development of Medical Ethics – a Sociological Analysis', in *Medical History*, vol. 191 (1975), 36-51.

Waddington, I, 'General Practitioners and Consultants in Early Nineteenth Century England: The Sociology of an Intra-Professional Conflict', in J Woodward & D Richards (eds.), *Health Care and Popular Medicine in Nineteenth Century England*, (London, 1977).

Waddington, I, *The Medical Profession in the Industrial Revolution*, (Dublin, 1984).

Waddington, I, 'The Movement Towards the Professionalisation of Medicine', *British Medical Journal* (1990), 690.

Waller, L, 'Secrets Revealed: the Limits of Medical Confidence', *Journal of Contemporary Health Law and Policy*, 9, (1993), 183-210.

Webster, C, 'The Metamorphosis of Dawson of Penn', in D Porter & R Porter (eds.), *Doctors, Politics and Society: Historical Essays*, (Amsterdam, 1993).

Wilkinson, A B, *The Scottish Law of Evidence*, (Edinburgh, 1986).

Worboys, M, 'Unsexing Gonorrhoea: Bacteriologists, Gynaecologists and Suffragists in Britain 1860-1920', *Social History of Medicine*, 17, (2004), 41-60.

Young, J, *Medical Ethics: An Address to the Glasgow University Medico-Chirurgical Society*, (Cupar-Fife, 1900).

Zamiatin, E, 'We', in B G Guerney (ed), *An Anthology of Russian Literature in the Soviet Period from Gorki to Pasternak*, (New York, 1960), 163-353.

Reference Works

The Dictionary of National Biography

The Medical Register

The Medical Directory

Who's Who

Who Was Who

Archival Material

Public Record Office, Kew, London (now the National Archives)

Ministry of Health Files:

Early interwar years – MH 78/253

1927/1928 - MH 55/184

Osbourne Convalescent Home. Disclosure of confidential documents – MH 55/184

Mental Deficiency Institutions. Patients condition and medical history. "Privileged" Correspondence – MH 58/98

Sir George Newman's Diary – MH 139/4

Lord Chancellor's Office File:

Medical Witnesses in Legal Proceedings: as to Position of – LCO 2/624

Birkenhead's War Office Papers – WO 374/6600

Privilege of Service Medical Records in Scotland in 1947-1948 – WO 32/12406

Chance Abortion Case – MEPO 3/1030

Case of the Kissing Doctor – MEPO 3/379

Russian Ambassador Request on Confidentiality – HO 45/9988/X72989

National Service Acts. Disclosure of Medical Records. Decision to continue the established practice of claiming privilege when called upon to produce medical reports in open court under subpoena (Robert Crossley v Dr H Williams of Birkenhead Medical Board, 1952) – LAB 6/620

Archive of the British Medical Association, BMA House, Tavistock Square, London

Minutes of the Central Ethical Committee 1914-1939

Minutes of the Professional Secrecy Committee 1921-1922

Minutes of the Special Committee on the Notification of VD 1922-23

Correspondence Files of Hempson (Lawyer to the BMA).

.

Newspapers, Journals, Law Reports

The British Medical Journal

The Daily Chronicle

The Lancet

The Law Journal

The Scots Law Times Reports

The Solicitors Journal

The Times Law Reports

Government Reports / Parliamentary Debates

Annual Reports of the Chief Medical Officer, (London, HMSO).

Hansard. Official Reports of Parliamentary Debates. House of Commons (particularly the years 1927 and 1936-7)

Interdepartmental Committee on Insurance Medical Records, (London, HMSO, 1920).

Royal Commission on Venereal diseases. Final Report of the Commissioners, (London: HMSO, 1916)

Online Resources

Internet Movie Database

<http://www.imdb.com>

Oxford Dictionary of National Biography
<http://www.oxforddnb.com>

Stair Memorial Encyclopedia (Scots Law online) accessed via:
<http://www.butterworths.co.uk>

The Times Digital Archive 1785-1985
<http://www.galegroup.com/Times>

Westlaw (legal database)
<http://uk.westlaw.com>