ing on the military and defense (49 per cent). People were asked: "To reduce the size of the federal deficit, would you be willing or not willing to have the government reduce proposed spending on programs for the poor?" Just 29 per cent said they would be willing; 63 per cent said they would not. Even the most malign of the transfer programs, such as food stamps, were supported by 57 per cent of the respondents.5

Similarly, one of the leading pollsters in the country, Lou Harris, has indicated that his polls since the end of last year have been showing (1) that by a very large majority (84%-12%), the American people do not want any rollback on the requirements of the Clean Air Act; (2) that by 62% to 34%, Americans would prefer military spending be cut before health programs; (3) a huge majority, 75% to 22%, do not want cuts in Medicare or Medicaid; (4) by 53% to 30% a majority opposes a ban in abortions.

Harris adds that "when people are asked whether to cut Medicare or defense, they vote to save Medicare by four to one; and when Medicaid is pitted against defense, it wins three to one." He concludes:

people all over the country have been profoundly shocked to find that the people running the country seem to be in favor of segregation, seem to want to abolish abortion and birth control, seem to want to abandon the poor and the elderly and the minorities . . . . and that the American people [think] that America could well be systematically stripped of all its compassion for decency and humanity . . . . but they are just beginning to get fighting mad about it. . . .6

Regarding industrial safety, 75 per cent of the respondents in a nationwide poll indicated that they favored keeping — without weakening — the current government regulations aimed at protection of the health and safety of workers.7

In summary, for many years, poll after poll has shown that the majority of Americans do not want cuts in health-care programs or in programs for the elderly and the poor, nor do they want a weakening of the health-related protection of the worker, consumer, and environment. In addition, and contrary to widely held beliefs, the majority of Americans are in favor of more, not less, government intervention in the health sector. Most Americans would be willing to pay even higher taxes if those taxes were spent on health services; they believe that there is a need for national health insurance and that it would require larger government intervention; they think that the benefits of government regulation of the costs of medical services and drugs outweigh the drawbacks; and they support federal control of doctor's fees, hospital costs, and prescription drugs.8,9 Indeed, there is very little evidence to support the frequently stated position that there is a popular mandate for cutting health programs and programs of assistance to the elderly and the needy, nor is there evidence of a popular mandate to weaken government health regulations. The reverse is true.

A popular mandate is what people want, and it is very clear that the current budgetary priorities of the Reagan administration, supported for the most part by Congress, are not representative of the people's wishes and wants. The majority of Americans do not want to see federal budgetary cuts in the areas where they are taking place. Agreeing with the need to balance the federal budget, most Americans believe (according to George Martin of Yankelovich, Skelly and White surveys) that "balancing should be done by cutting down defense, increasing corporate taxes and not by cutting social (including medical and health) services."2

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Note added in proof: A further note needs to be added to this article, which was written before the November elections. Those elections showed a general dissatisfaction with the Reagan administration's policies, confirming the findings of this article. Indeed, it would be wrong to interpret this election's outcome as a mere change in the mood of the voting population — i.e., a move from the right to the center. The majority of the registered voting population did not vote for Reagan in 1980, and even among those who did, there is evidence that many did not support his social policies. The findings presented in this article show that the American people are not as volatile in their opinions and views as they are usually assumed to be. This survey of opinion polls shows a consistent pattern of support for certain types of government programs and policies. It is not the people's purported volatility but, rather, the inability and unwillingness of their government leaders to carry out those policies that explain the disenchantment with current and previous administrations.

References

Confidentiality in Medicine — A Decrepit Concept

Medical confidentiality, as it has traditionally been understood by patients and doctors, no longer exists. This ancient medical principle, which has been included in every physician's oath and code of ethics since Hippocratic times, has become old, worn-out, and useless; it is a decrepit concept. Efforts to preserve it appear doomed to failure and often give rise to more problems than solutions. Psychiatrists have tacitly acknowledged the impossibility of ensuring the confidentiality of medical records by choosing to establish a separate, more secret record. The following case illustrates how the confidentiality principle is compromised systematically in the course of routine medical care.
A patient of mine with mild chronic obstructive pulmonary disease was transferred from the surgical intensive-care unit to a surgical nursing floor two days after an elective cholecystectomy. On the day of transfer, the patient saw a respiratory therapist writing in his medical chart (the therapist was recording the results of an arterial blood gas analysis) and became concerned about the confidentiality of his hospital records. The patient threatened to leave the hospital prematurely unless I could guarantee that the confidentiality of his hospital record would be respected.

This patient’s complaint prompted me to enumerate the number of persons who had both access to his hospital record and a reason to examine it. I was amazed to learn that at least 25 and possibly as many as 100 health professionals and administrative personnel at our university hospital had access to the patient’s record and that all of them had a legitimate need, indeed a professional responsibility, to open and use that chart. These persons included 6 attending physicians (the primary physician, the surgeon, the pulmonary consultant, and others); 12 house officers (medical, surgical, intensive-care unit, and “covering” house staff); 20 nursing personnel (on three shifts); 6 respiratory therapists; 3 nutritionists; 2 clinical pharmacists; 15 students (from medicine, nursing, respiratory therapy, and clinical pharmacy); 4 unit secretaries; 4 hospital financial officers; and 4 chart reviewers (utilization review, quality assurance review, tissue review, and insurance auditor). It is of interest that this patient’s problem was straightforward, and he therefore did not require many other technical and support services that the modern hospital provides. For example, he did not need multiple consultants and fellows, such specialized procedures as dialysis, or social workers, chaplains, physical therapists, occupational therapists, and the like.

Upon completing my survey I reported to the patient that I estimated that at least 75 health professionals and hospital personnel had access to his medical record. I suggested to the patient that these people were all involved in providing or supporting his health-care services. They were, I assured him, working for him. Despite my reassurances the patient was obviously distressed and retorted, “I always believed that medical confidentiality was part of a doctor’s code of ethics. Perhaps you should tell me just what you people mean by ‘confidentiality’?”

**Two Aspects of Medical Confidentiality**

**Confidentiality and Third-Party Interests**

Previous discussions of medical confidentiality usually have focused on the tension between a physician’s responsibility to keep information divulged by patients secret and a physician’s legal and moral duty, on occasion, to reveal such confidences to third parties, such as families, employers, public-health authorities, or police authorities. In all these instances, the central question relates to the stringency of the physician’s obligation to maintain patient confidentiality when the health, well-being, and safety of identifiable others or of society in general would be threatened by a failure to reveal information about the patient. The tension in such cases is between the good of the patient and the good of others.

**Confidentiality and the Patient’s Interest**

As the example above illustrates, further challenges to confidentiality arise because the patient’s personal interest in maintaining confidentiality comes into conflict with his personal interest in receiving the best possible health care. Modern high-technology health care is available principally in hospitals (often, teaching hospitals), requires many trained and specialized workers (a “health-care team”), and is very costly. The existence of such teams means that information that previously had been held in confidence by an individual physician will now necessarily be disseminated to many members of the team. Furthermore, since health-care teams are expensive and few patients can afford to pay such costs directly, it becomes essential to grant access to the patient’s medical record to persons who are responsible for obtaining third-party payment. These persons include chart reviewers, financial officers, insurance auditors, and quality-of-care assessors. Finally, as medicine expands from a narrow, disease-based model to a model that encompasses psychological, social, and economic problems, not only will the size of the health-care team and medical costs increase, but more sensitive information (such as one’s personal habits and financial condition) will now be included in the medical record and will no longer be confidential.

The point I wish to establish is that hospital medicine, the rise of health-care teams, the existence of third-party insurance programs, and the expanding limits of medicine all appear to be responses to the wishes of people for better and more comprehensive medical care. But each of these developments necessarily modifies our traditional understanding of medical confidentiality.

**The Role of Confidentiality in Medicine**

Confidentiality serves a dual purpose in medicine. In the first place, it acknowledges respect for the patient’s sense of individuality and privacy. The patient’s most personal physical and psychological secrets are kept confidential in order to decrease a sense of shame and vulnerability. Secondly, confidentiality is important in improving the patient’s health care — a basic goal of medicine. The promise of confidentiality permits people to trust (i.e., have confidence) that information revealed to a physician in the course of a medical encounter will not be disseminated further. In this way patients are encouraged to communicate honestly and forthrightly with their doctors. This bond of trust between patient and doctor is vitally important both in the diagnostic process (which relies on an accurate history) and subsequently in the treatment phase,
which often depends as much on the patient’s trust in the physician as its does on medications and surgery. These two important functions of confidentiality are as important now as they were in the past. They will not be supplanted entirely either by improvements in medical technology or by recent changes in relations between some patients and doctors toward a rights-based, consumerist model.

**Possible Solutions to the Confidentiality Problem**

First of all, in all nonbureaucratic, noninstitutional medical encounters — that is, in the millions of doctor–patient encounters that take place in physicians’ offices, where more privacy can be preserved — meticulous care should be taken to guarantee that patients’ medical and personal information will be kept confidential.

Secondly, in such settings as hospitals or large-scale group practices, where many persons have opportunities to examine the medical record, we should aim to provide access only to those who have “a need to know.” This could be accomplished through such administrative changes as dividing the entire record into several sections — for example, a medical and financial section — and permitting only health professionals access to the medical information.

The approach favored by many psychiatrists — that of keeping a psychiatric record separate from the general medical record — is an understandable strategy but one that is not entirely satisfactory and that should not be generalized. The keeping of separate psychiatric records implies that psychiatry and medicine are different undertakings and thus drives deeper the wedge between them and between physical and psychological illness. Furthermore, it is often vitally important for internists or surgeons to know that a patient is being seen by a psychiatrist or is taking a particular medication. When separate records are kept, this information may not be available. Finally, if generalized, the practice of keeping a separate psychiatric record could lead to the unacceptable consequence of having a separate record for each type of medical problem.

Patients should be informed about what is meant by “medical confidentiality.” We should establish the distinction between information about the patient that generally will be kept confidential regardless of the interest of third parties and information that will be exchanged among members of the health-care team in order to provide care for the patient. Patients should be made aware of the large number of persons in the modern hospital who require access to the medical record in order to serve the patient’s medical and financial interests.

Finally, at some point most patients should have an opportunity to review their medical record and to make informed choices about whether their entire record is to be available to everyone or whether certain portions of the record are privileged and should be accessible only to their principal physician or to others designated explicitly by the patient. This approach would rely on traditional informed-consent procedural standards and might permit the patient to balance the personal value of medical confidentiality against the personal value of high-technology, team health care. There is no reason that the same procedure should not be used with psychiatric records instead of the arbitrary system now employed, in which everything related to psychiatry is kept secret.

**Afterthought: Confidentiality and Indiscretion**

There is one additional aspect of confidentiality that is rarely included in discussions of the subject. I am referring here to the wanton, often inadvertent, but avoidable exchanges of confidential information that occur frequently in hospital rooms, elevators, cafeterias, doctors’ offices, and at cocktail parties. Of course, as more people have access to medical information about the patient the potential for this irresponsible abuse of confidentiality increases geometrically.

Such mundane breaches of confidentiality are probably of greater concern to most patients than the broader issue of whether their medical records may be entered into a computerized data bank or whether a respiratory therapist is reviewing the results of an arterial blood gas determination. Somehow, privacy is violated and a sense of shame is heightened when intimate secrets are revealed to people one knows or is close to — friends, neighbors, acquaintances, or hospital roommates — rather than when they are disclosed to an anonymous bureaucrat sitting at a computer terminal in a distant city or to a health professional who is acting in an official capacity.

I suspect that the principles of medical confidentiality, particularly those reflected in most medical codes of ethics, were designed principally to prevent just this sort of embarrassing personal indiscretion rather than to maintain (for social, political, or economic reasons) the absolute secrecy of doctor–patient communications. In this regard, it is worth noting that Percival’s Code of Medical Ethics (1803) includes the following admonition: “Patients should be interrogated concerning their complaint in a tone of voice which cannot be overheard.” * We in the medical profession frequently neglect these simple courtesies.

**Conclusion**

The principle of medical confidentiality described in medical codes of ethics and still believed in by patients no longer exists. In this respect, it is a decrepit concept. Rather than perpetuate the myth of confidentiality and invest energy vainly to preserve it, the public and the profession would be better served if they devoted their

attention to determining which aspects of the original principle of confidentiality are worth retaining. Efforts could then be directed to salvaging those.

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MASSACHUSETTS MEDICAL SOCIETY

DEATHS

DeCesare — Nicandro Francis DeCesare, M.D., of Methuen, died on October 29. He was in his 88th year.

Dr. DeCesare received his degree from Tufts College Medical School in 1920. He was a member of the American Medical Association, the American Society of Abdominal Surgeons, and the International College of Surgeons. He was a 50-year member of the Massachusetts Medical Society.

Gaudreau — Honore Edward Gaudreau, M.D., of Ludlow, died on October 24. He was in his 83rd year.

Dr. Gaudreau received his degree from Tufts College Medical School in 1924. He was a member of the American Academy of Ophthalmology and Otolaryngology, the American College of Surgeons, and the American Medical Association. He was a 50-year member of the Massachusetts Medical Society.

Ginsberg — Max Ginsberg, M.D., formerly of Salem, died on November 3. He was in his 76th year.

Dr. Ginsberg received his degree from Tufts College Medical School in 1933.

Levine — Harry Levine, M.D., of Fall River, died on October 3. He was in his 72d year.

Dr. Levine received his degree from Middlesex University School of Medicine in 1936. He was a member of the American Medical Association, the American Academy of General Practice, and the Aerospace Medical Association.

Matern — Herman Ludwig Matern, M.D., formerly of Worcester, died on September 14. He was in his 80th year.

Dr. Matern received his degree from Hahnemann Medical College in 1929. He was a 50-year member of the Massachusetts Medical Society.

Pinto — Sherman Spalding Pinto, M.D., of Tacoma, Wash., died on April 21. He was in his 76th year.

Dr. Pinto received his degree from the University of Nebraska College of Medicine in 1932. He was a member of the American Medical Association, the American Academy of Occupational Medicine, and the Industrial Medical Association.

Spector — Nathan Moses Spector, M.D., of Willimantic, Conn., died on April 19. He was in his 81st year.

Dr. Spector received his degree from Tufts College Medical School in 1924. He was a member of the American Medical Association and the American College of Obstetricians and Gynecologists.

Stein — Calvert Stein, M.D., of Longmeadow, died on October 20. He was in his 80th year.

Dr. Stein received his degree from Tufts College Medical School in 1928. He was a member of the American Medical Association, the American Academy of Neurology, the American Psychiatric Association, and the American Academy of Psychosomatic Medicine. He was a past president of the American Society of Clinical Hypnosis and of the American Society of Group Psychotherapy and Psychodrama, and a 50-year member of the Massachusetts Medical Society.

Streim — Benjamin Streim, M.D., of Belmont, died on July 5, 1981. He was in his 68th year.

Dr. Streim received his degree from Kansas City University of Physicians and Surgeons in 1943. He was a member of the American Academy of General Practice.

CORRESPONDENCE

Letters to the Editor are considered for publication (subject to editing and abridgment), provided that they are submitted in duplicate, signed by all authors, typewritten in double spacing, and do not exceed 1 ½ pages of text (excluding references). They should not duplicate similar material being submitted or published elsewhere. Letters referring to a recent Journal article should be received within six weeks of the article’s publication. We are unable to provide pre-publication proofs, and unpublished material will not be returned to authors unless a stamped, self-addressed envelope is enclosed.

SCREENING FOR RISK OF ACQUIRED IMMUNE-DEFICIENCY SYNDROME

To the Editor: Acquired immune-deficiency syndrome (AIDS) is a disorder that has recently been noted among homosexual men, Haitians, and persons with hemophilia.1,2 It is characterized by unusual malignant conditions, such as Kaposi’s sarcoma, non-Hodgkin’s lymphoma, and Burkitt’s lymphoma, as well as by increased frequency and severity of opportunistic infections that require a cell-mediated immune response. The immunologic defects include altered ratios of certain T-cell subsets, with diminished numbers of helper-inducer T cells and apparently normal numbers of suppressor-cytotoxic T cells in the peripheral blood.3,4 These phenotypic abnormalities have been recognized largely by monoclonal antibodies that detect certain cell-surface markers, which in turn have been associated with particular functional activities. Indeed, those functional activities are based on what may well be a limited insight into the full capacity of a particular phenotype for cellular immune function.

The commercial availability of these monoclonal reagents, together with the urgency of identifying persons who may be affected by AIDS, has prompted a number of laboratories throughout the country to offer T-cell phenotyping. It is implied that this is a known, standardized evaluation of the immune system and its functional state, capable of predicting the risk of AIDS and its complications. Such commercialized screening is inappropriate at this time.

The criteria for screening tests should have been frequently discussed and should be heeded.2,5 The test should be accurate, reliable, and reproducible, and its specificity and sensitivity should be known for accurate interpretation. As in various forms of genetic screening, the