

The right and duty of secrecy, as a patient protection

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Abstract

The text reflects on the duty of professional secrecy about the information received from patients during medical assistance in order to respect the right and protection of the patient. In spite of being one of the most traditional moral concepts in health care, secrecy is still one of the less respected principles. This is particularly worrying considering our times of intense exposition of privacy. The guarantee of confidentiality, besides stimulating the link between patient and health professional, could favour the assent to a treatment and more independent decision making as the guarantee ensures the patient that aspects of his or her personal life that could cause judgement will not be exposed. The secrecy, in this context, works as a mechanism of protection for the patient in regard to the patient's values and personal experiences, supporting the necessary confidence in the doctor - patient relationship.

Keywords: Confidentiality. Privacy. Physician-patient relations.

Resumo

O direito-dever de sigilo na proteção ao paciente

O texto reflete sobre o dever de sigilo profissional em saúde quanto às informações recebidas do paciente durante a assistência médica como cumprimento de um direito desse paciente, bem como de sua proteção. Embora tido como um dos mais tradicionais preceitos morais da assistência em saúde, o sigilo ainda é um dos princípios menos respeitados, fato particularmente preocupante em épocas de intensa exposição da intimidade como os tempos atuais. De outro lado, a garantia da confidencialidade, além de estimular o vínculo profissional-paciente, pode favorecer a adesão ao tratamento e a tomada de decisões mais autônomas, ao assegurar ao paciente a não exposição de circunstâncias de sua vida pessoal que possam ensejar julgamentos que ele deseja evitar, mesmo aos entes mais próximos. O sigilo, nesse contexto, funciona como mecanismo de proteção ao paciente no tocante a seus valores e vivências pessoais, lastreando a necessária confiança na relação médico-paciente.

Palavras-chave: Confidencialidade. Privacidade. Relações médico-paciente.

Resumen

El derecho-deber de sigilo en la protección al paciente

El texto reflexiona acerca del deber de confidencialidad profesional en salud en relación a las informaciones recibidas de parte del paciente durante la asistencia médica, como cumplimiento de un derecho de este paciente, así como para su protección. Aunque se trate de uno de los más tradicionales preceptos morales de la asistencia en salud, la confidencialidad sigue siendo uno de los principios menos respetados, hecho particularmente preocupante en épocas de intensa exposición de la intimidad como lo son los tiempos actuales. Por otro lado, la garantía de la confidencialidad, además de estimular el vínculo profesional-paciente, puede favorecer la adhesión al tratamiento y la toma de decisiones más autónomas, al asegurar al paciente la no exposición de circunstancias de su vida personal que puedan dar lugar a juicios que él desea evitar, incluso con entes muy próximos. La confidencialidad, en este contexto, funciona como un mecanismo de protección al paciente en lo relacionado a sus valores y vivencias personales, posibilitando la confianza necesaria en la relación médico-paciente.

Palabras-clave: Confidencialidad. Privacidad. Relaciones médico-paciente.

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Declara não haver conflito de interesse.

*Don't open yourself to your friend
because he has another friend
And the friend of your friend
has friends too ...*

Mario Quintana¹

Confidentiality and respect for privacy are traditional moral precepts of health professions and are indicative of the duty of secrecy of professionals, regarding data about a third party, obtained through the exercise of his or her work. The professional/patient relationship must be guided by the trust based on the duty of professional secrecy.

Some refer to secrecy as the duty to keep a secret, and the secret as the object of secrecy. There will be no such distinction here inasmuch as the distinction is irrelevant to this study. In any case, professional secrecy has been, nowadays, associated with the bioethical principle of autonomy considering that personal data belong to the patient, who is the only one who can decide, a priori, to whom he or she wants to give information. The doctor, nurse, psychologist, as recipients of those data, by virtue of their profession, should not disclose the information except by permission of the patient or in exceptional circumstances, outlined by the law and ethics, such as cases of compulsory notification provided by law and regulations, wherein the professional must breach the secrecy because of epidemiological criteria from the public health system.

However, even before the recognition of bioethical principles and fundamental human rights, the duty of professional confidentiality was already required from health professionals, particularly doctors. The Hippocratic Oath preached that *"Into whatever houses I enter... Whatever, in connection with my professional practice or not, in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. (Translation from Greek by Francis Adams – 1849)"*^{2,3}.

Regardless of being such an old precept in healthcare, the duty of secrecy is, still to this day, one of the ethical commitments most disrespected in the day-to-day of hospitals and health facilities. See, for example, how widespread are conversations in corridors and elevators about illnesses of patients or even how often medical records, with names of patients and their diagnostics, are placed in public areas. Even the physical disposition of stretchers and medical beds allow unnecessary exposure of patients. Somehow, the information technology has reduced this risk, but it is still difficult to determine

who should have access to the data and how to protect them from external interferences.

Maintaining secrecy is a measure that allows individuals to protect their peculiarities, idiosyncrasies and the privacy of their way of life, allowing them to choose what to reveal to the judgment of the outside world or even the judgment of people who are close to them. It is reasonable to claim that the proper respect for secrecy in health care not only would avoid many controversies, but it would also ensure greater freedom to patients and to the decision making concerning health care, which would allow the effective exercise of those patients' individuality. That's because even privacy has concentric spheres, among which the privacy of medical records is one of the most inward and significant.

A brief comment is made in this paper about professional secrecy as a right of the patient, duty of the professional and protection mechanism for the patient, in his or her autonomy. We also indicate some of the main aspects in which professional secrecy should be observed in daily practice, as well as some of its ethical and legal implications.

Who owns the secret: respect for the modesty and privacy of the patient

As we've seen, the secrecy is simultaneously a right of the patient and a duty of the professional. For Diego Gracia⁴, it is even more a duty than a right, as it is based on a commitment of protection that can outrank the applicant's request. Secrecy is expected from all those who have access to the patient's personal data because of their professional activity.

So doctors, nurses, technical assistants, psychologists, social workers - who received information directly from the patient - as well as other professionals such as archivists and auditors, who had access to the patient's medical records, are required to keep secret about all that they know because of their work^{2,3,5-7}.

In this area, it is necessary to recommend particular care with medical records, which should not be accessible to any person, and to refrain from indiscreet hallway conversations⁸, even with professional colleagues, which would enable the identification of the patient, avoiding passing on information that only concerns the patient, in order to preserve his or her privacy. Indeed, even the discussion of cases among professionals, supported by similar duty of secrecy, or in teaching, must preserve as much as possible, the identity of the patient.

It should be remembered that patients who expose their secrets and privacy to a professional don't do so by choice but, above all, by necessity. Having chosen or needing to resort to a professional in particular, patients, at that moment, intend to reveal their data to that professional alone.

Questioning on the other hand from whom one should keep secret, it is to be observed that secrecy is extensive to all those who do not have strict necessity to have access to the mentioned data, observing the specific benefit of the patient, who is responsible to authorise any other case. Even companions should be informed, as a rule, if and when the patient consents, except in cases of incapacitated patients, when the legal guardian will be responsible to authorise or not information to others.

This care does not exempt nor allow even other health professionals to receive information, if they do not act in the care of the patient and were not authorised by him or her. If health professionals act in the care of a patient, their level of information should also be limited - besides what they were told by the patient - to the elements which are essential to their adequate professional performance. In both situations and also if they happen to be aware of other data, the professional should maintain secrecy about the information.

On the other hand, the patient should not confuse the duty of secrecy with the right to the information necessary to his or her decision-making, whilst knowing that, being private, his or her data will only be exposed in exceptional cases. The full and adequate exercise of autonomy requires, as it is known, the effective clarification and the free consent about the procedures to which the patient will be submitted. In this context, what is possible is called the right of not to know, if this is the patient's desire - although, in most cases, what happens is in fact a desire not to be reminded of his or her disease...⁹ What we want to emphasise is that the duty of secrecy exists in the face of others, and should not be held against the patient, to whom the personal data are related.

The object of the protection of the professional secrecy is associated with privacy in its more inward sphere. The right to privacy, according to Costa Junior¹⁰, originated from the recognition of the Anglo-Saxon law in the 19th century to the right to be alone. This right consists of concentric spheres of protection, embracing more internally the protection of privacy and of the so-called circle of secrecy, to which only individuals selected by the interested person can have access. Secrecy

serves, therefore, the protection of the privacy of the patient, his or her personal information, choices or life events, test results, modesty, physical and moral images.

Professional secrecy, research, teaching and right to non exposure of the image

Regarding the protection of the physical image, for example, a particular zeal is necessary in the clinical examination of the patient, even if a child. Although the conditions of care and examination, especially in emergency units and collective wards, are not always ideal, it is recommended to respect and as much as possible, to protect the natural modesty of the individual, sparing him or her from unnecessary exposure, which would consist of one more aggression towards someone who is already weakened. It is advisable, therefore, to use curtains of separation between beds during tests and procedures in order to avoid attracting the curiosity of other patients and companions.

The prior information and clarification about the procedure to be performed, besides being an important element in the establishment of the professional-patient relationship and in the obtainment of consent, is also an indicative of respect for the privacy of the patient - even in the case of children and incapable patients in general (according to the limits of their cognition) - helping to overcome natural modesty and to allow for a quieter examination or procedure.

The same is true regarding the use of the patient's image, even for teaching purposes. The use of images must be preceded by informed consent. This is valid for photographic images of external body parts, for example, or images originated from diagnostic methods which involve unidentifiable images, that is, internal organs, such as radiologic images. All those kinds of images refer to body parts of an individual who, therefore, is responsible for allowing or not their divulgation.

Indeed, secrecy should be observed in teaching activities, so that usual visits of students to the bedside should be preceded by information to the patient and his or her consent. Moreover, we must be careful to avoid comments on diagnosis, prognosis or other personal data in front of other patients or companions.

Students should be taught from the beginning that patients are not mere "interesting cases", but human beings deserving of respect, especially con-

sidering their particular vulnerability . One should treat others as one would like to be treated, without forgetting that this does not make the professional a judge of what should or should not be secret, because even information that to others may appear personally banal and for whom its disclosure would be irrelevant, could be considered extremely sensitive to the patient, given her or his scale of values. Therefore, the rule has to be to maintain secrecy about all data relating to the patient, prohibiting unnecessary comments. The secret belongs to the patient and only the patient decides what can be revealed and to whom, the professional being simply a faithful custodian.

Also the researcher and collaborators, when they access data from medical records or patient information, should commit themselves to secrecy about what was found due to the survey, as required by the regulation on the matter present in the Resolution 466/2012 of the Conselho Nacional de Saude (Health National Council) ¹¹.

Still with regard to research, even because of regulatory requirement, it is always important to make clear, in the presentation of the project, the researcher's confidentiality commitment to the obtained data. This requirement extends to studies conducted with medical records, in which, no longer being possible to obtain the patient's consent , must contain an explicit commitment on the part of all who have access to documents that the research subjects will not be identified and their personal data will not be exposed. In addition, information that enables identification will not be shared^{5 12}.

Duty of confidentiality and protection of autonomy

The duty of professional secrecy is also a patient's right from the point of view of the effective exercise of the patient's autonomy through the protection of the existential privacy and its influence in decision-making. The duty of secrecy as protection of autonomy includes the patient's right to decide freely, solely according to the law and to the patient's own way of thinking. Therefore, this commitment is part of the framework of respect and recognition of the role of patients in health decisions regarding their own health.

The decision making process in this context takes into account not only the technical information provided by professionals about the clinical condition of a patient but it also considers the social,

mental, emotional and cultural aspects involved as well as the impact that the decision will have in future. Human beings, as the social creatures that they are, live in interaction. However, despite the era of harsh exposure (consented or not) that we now live in, the fact is that certain personal aspects should have their social exposure modulated and determined solely by the principal involved, who will suffer the most direct consequences of the spread of such information.

This concern motivated the 1988 constituent assembly and the infra-constitutional legislation to provide for the possibility of punitive damages and other penalties in cases of not consented exposure, be the exposure in relation to physical image or in relation to information that could negatively change the social image, in his or her environment, of the person affected. In the case of decisions in the health area, they will only be taken in the sphere of effective autonomy, ensuring that they will not receive interference, as a determining factor, from the fear of the social impact of a virtual knowledge of data that should only be revealed by the patient to whom he or she decides and at the moment and extension that suits the patient. Secrecy will allow, in this case, to fully exercise the right to individuality, diversity and the constitutional liberties through the guarantee of secretive consent or refusal.

This situation has arisen, as a frequent example in the case of Jehovah's Witnesses, when the capacitated patient is consulted on the permission or not to receive blood. That patient's conscious refusal of such treatment - possibility that we advocate - should be observed by guaranteeing full confidentiality, including with respect to data access and possible authorisation entered on medical records, in order to ensure the most reliable possible answer, as the patient is accountable only to his or her conscience in regards to the decision making. Indeed, perhaps because of the guarantee of full confidentiality about their decision, patients would be willing to authorise procedures that they are not comfortable with in public when they are subjected, before the dictates of their own conscience, to exterior judgment even if only from their loved ones.

The same weighting refers to situations involving abortion (even being lawful), reproductive capacity, sexually transmitted diseases treatment (which interest only the partners, as it will be mentioned ahead), drug use, and even cancer (which remains, in many social environments, to this day, as "the disease that should not be named"). It should be remembered, in fact, that the patient goes to the

doctor to be treated, not to be judged or to have her or his privacy exposed. Therefore, the patient is the sole responsible for ethical decisions on procedures that he or she legally accepts to submit to and it is the patient who should weigh up whether the social burden of the decision does not outweigh his or her private consciousness.

Assuring secrecy guarantees the right of individuals to their idiosyncrasies, the personal management of their relations, the autonomy over decisions concerning their health, respect for the diversity of thought and the particular circumstances that affect it, as well as the safeguarding, as much as possible, of the freedom of decisions about health when facing external judgment pressures.

Confidentiality and teenager care

Admittedly, when it comes to an adult patient, lucid and capacitated, only the patient can decide who will have access to his or her data. Therefore, the information should be preceded by authorisation of the patient even if requested by his or her companions.

As for the child or legally incompetent adult, the legal guardians are in charge of the patient's personal information - although it would be positive to get the participation of those patients in the decision making, whenever possible, through information compatible with their level of understanding, encouraging their commitment to their own health and stimulating their participation in treatments.

A doubt arises, however, particularly regarding adolescents or, more precisely, the legally incompetent but who, because of some degree of autonomy and maturity, can manifest the desire against the communication of certain information about him or her to the legal responsible.

Notice that the breach of confidentiality in these situations can pose a serious breach of trust, when the teenager is driven to move away from the professional and fails to recur to the professional in order to clear doubts. It could also cause those teenagers to omit information relevant to their care. In this context, there are many authors who defend the concept of mature minor, presented by the Society for Adolescent Health and Medicine, in the 1970s, as a proposal for a moderate exercise of self-management, which values the privacy, confidentiality and the relative autonomy of adolescents¹³⁻¹⁹. The mentioned Society supports the concept that individuals can exercise their

rights, provided that they have the maturity to understand them²⁰.

Such provision specifies that both invasive procedures involving risks as well as the circumstances under which treatment is indispensable should also be reported to patients who are minor, from whom it is necessary to obtain consent, as much as possible, whilst recognising that the legal authorisation depends on the legal responsible, since they are not legally autonomous individuals. In case of conflict between the autonomy of parents as surrogate decision-makers and the beneficence of the minor, the pro beneficence understanding will prevail because this is, in fact, a situation of heteronomy.

One should, however, communicate and clarify minors on the need for medical intervention, answering their questions and promoting their participation in the decision-making, assuring, as much as possible, the maximum confidentiality on information about the minors. In regard to the theory of mature minors it is advocated that, if a refusal with supposedly harmful effects comes from the adolescents themselves, and not from their representatives, the refusal should be accepted as far as possible, as long as the maturity of the adolescent to deal with the matter is recognised and possibilities of false autonomy, such as the one due to external pressures or failure to understand the consequences of the decision, are discarded.

This thesis, though not expressly adopted in Brazil, can be seen in national and international normative precepts, such as the appreciation of what minors have to say and their gradual autonomy, provided by the articles, related to fundamental rights, of the Brazilian Child and Adolescent Statute (abbreviated as ECA in Brazil, for Estatuto da Criança e do Adolescente), from 1990, and the Declaration of Ottawa on Child Health, from 1998. In this regard, the Brazilian Code of Medical Ethics from 2010 (abbreviated as CEM in Brazil, for Código de Ética Médica) also establishes in its article 74 that: [It is prohibited to the doctor] to reveal professional secrecy related to minors, including parents or legal representatives, as long as the minor has discernment capacity, unless the non-disclosure may cause harm to the patient²¹.

Based on this article from the CEM, individual consultations with teenagers are recognised and even recommended. It is an occasion when more accurate information about a teenager's health and lifestyle habits might be obtained. This information, a priori, should be kept confidential even from the legal responsible if the patient has, in the words of

Article 103 of the Brazilian Code of Medical Ethics from 1988, which preceded the current one, *competence to evaluate his or her problem and act by his or her own means to solve it*²² - That said, the difficulty of evaluating these aspects in an emergency consultation is also considered.

But when the situation involves risks to the patient such as, for example, pregnancy (with the consequent risk of miscarriage), drug use, suicidal ideas - then the communication of the professional to the legal representatives becomes compulsory, but not before encouraging adolescents to do it themselves. The parents, if applicable, should be referred to the specialised support of a psychologist, social worker etc. It is a situation where the patient must not be lost from sight, since he or she is at risk^{3,23,24}.

Legal and deontological duty to keep a secret

The duty of secrecy is not only ethical, but legal. Internationally, the Universal Declaration of Human Rights, from 1948, provides in its Article XII: *No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks*²⁵. Still at the international level, the International Code of Medical Ethics adopted by the World Medical Association (WMA) in 1949, states that *a physician shall respect a patient's right to confidentiality*²⁶.

The Brazilian Constitution of 1988 provides, in the title about the fundamental principles: *Article 5 X – the privacy, private life, honour and image of persons are inviolable, and the right to compensation for property or moral damages resulting from their violation is ensured*²⁷. And the Penal Code qualifies the violation of professional secrecy as a crime, in the following terms: *Art 154 - if someone reveals without cause a secret which is known because of function, ministry, trade or profession, and whose revelation can produce damage to others. Penalty - detention of three months to one year or a fine*²⁸. It is understood, from a jurisprudential point of view, that this legal disposition includes the conduct of the doctor who attends patients with abortion history and who is not required to notify the offence⁵.

The Brazilian Code of Criminal Procedure, in turn, in its article 207, prohibits the testimony of people who, because of function, ministry, trade or profession, are required to keep a secret unless they

are given permission by the interested party and want to give their testimony²⁹. Once summoned they should go to court but only to inform their impossibility to testify, considering the ethical and legal duty of secrecy. Similar provisions are contained in the Brazilian Civil Code in its Article 229: *No one may be compelled to testify about facts: I - about which, by status or profession, should keep secret*³⁰; and the Code of Civil Procedure, in its Article 347, says that: *The party is not required to give evidence of facts: (...) II - about which, by status or profession, should maintain confidentiality*³¹.

As a result, the medical record, where there is sensitive data about the patient, can not be displayed even to the judiciary without permission of the patient to whom the data belongs: the patient, whilst the health unit acts only as a faithful custodian. These provisions are consistent with the provisions of codes of ethics for health professionals, highlighting, in the 2010 CEM, the principle XI: *Doctors will keep secrecy about information they hold knowledge because of the performance of their duties, with the exception of cases provided by law*²². The chapter IX, which is specifically about medical confidentiality, should also be highlighted. The medical reports may only be disclosed with permission of the patient or the responsible, in the case of incompetent patients.

In the same vein, the Nursing Professionals Ethics Code expressed similar concern in its Article 29, when it establishes, among the duties of those professionals, to maintain secrecy on confidential fact that they *have knowledge by reason of their professional activity, except in cases provided by law*. The Article 54 also adds, among the prohibitions: *To publish works with elements that identify the patient without his or her consent*³².

Other ethics codes in healthcare reiterate that concern, as can be seen in the Code of Professional Ethics of Physiotherapy and Occupational Therapy (Article 7 VIII: *Keep secret about sensitive data brought to attention because of their professional activities and require the same behaviour from staff under your direction*³³) and the Code of Ethics of the Social Worker, where secrecy is presented simultaneously as right (Article 15: *It is a right of the Social Worker to maintain professional secrecy*) and as a professional duty (Article 17: *The social worker is forbidden to reveal confidential information*³⁴).

Article 20 of the last code mentioned prohibits social workers to *give evidence, as witnesses, about the user on secretive situations that they have knowledge of due to their professional practice,*

even when authorised to do so³⁴. This requirement calls attention because it is more restrictive than the procedural and civil law of the country, which provide the option to the professional, when the patient authorises, to reveal secrets obtained this way. But the professional, in this case, will not be punished if he or she, even being authorised, does not want to reveal confidential information.

Article 9 of the Universal Declaration on Bioethics and Human Rights acts in the same direction when it defines, quite accurately, the following directive: *The privacy of the persons concerned and the confidentiality of their personal information should be respected. To the greatest extent possible, such information should not be used or disclosed for purposes other than those for which it was collected or consented to, consistent with international law, in particular international human rights law*³⁵.

Breach of confidentiality causes

The imperative of secrecy, however, involves exceptions. The discussion on the possible need for secrecy flexibility gained ethical and legal space in the event that became known as Case Tarasoff 36, occurred in 1969. This is the case of a student at the University of California, Prosenjit Poddar, who killed the student Tatiana Tarasoff, having previously reported to doctor Lawrence Moore, who attended him professionally, his intention of killing the young woman. He even informed the time when he would attempt the murder.

The professional consulted with his supervisor whether or not he should breach confidentiality in this case, warning Ms. Tarasoff about the threat to her life. They decided not to warn Tatiana Tarasoff, considering the respect for professional confidentiality. Tatiana Tarasoff, alone in her home, was first shot and then stabbed to death by Poddar. The parents of the victim filed a lawsuit against the university, obtaining favourable ruling.

From then on it was, in general, determined that situations involving risk of life for oneself or others should be reported to the appropriate authorities and legal guardians. This includes proven or suspicious situations (only if based on reasonable grounds) of children and adolescents maltreatment as well as episodes of notifiable diseases. This provision is clear, *exempli gratia*, in the article 18 of the Brazilian Code of Ethics of the Social Worker: *A breach of confidentiality shall be admissible only in situations which seriousness can, whether or not in-*

*volving criminal fact, bring harm to the user, third parties and the community. Sole Paragraph - The revelation will be made within the limits necessary, whether on the subject revealed or the extent and number of people that should be informed*³⁴.

With respect to risk situations, one example that creates doubts is the knowledge of a diagnosis of HIV seropositivity, a circumstance that usually generates great anxiety among health professionals, who understand that this information should be automatically communicated not only to sexual partners but also to other colleagues, laboratory personnel etc. in order to prevent the risk of contamination of these professionals. Note, however, that in this case the breach of confidentiality is unfounded, considering that adequate health care measures should be universal and should not depend, therefore, on information on HIV seropositivity to be applied. In addition, AIDS is not the only blood-borne serious infection, not to mention the many patients who have AIDS but whose diagnosis is not known during health care. In this sense, it is important to note that the fact that a notifiable disease is a legal reason for breach of confidentiality does not, however, imply an indiscriminated disclosure of the information, even among team members, except if necessary for the treatment. The staff of the public authority which received the communication is expected to act with discretion, in a way that the care and necessary epidemiological conduct which cause the inclusion of the illness among the notifiable diseases, do not cause unnecessary exposure and source of discrimination and embarrassment to the patient.

Somehow, this understanding led to the alteration of the CFM (Conselho Federal de Medicina- Federal Medical Council) Resolution 1,359 / 1992, which provided the express communication to sexual partners and sharers of syringes³⁸, for the CFM Resolution 1,665 / 2003, seen as more in line with the Declaration of Madrid, adopted by the WMA in 1987³⁷. In this regard, the resolution provides for the immediate and direct information only to health workers for which this data is of unequivocal importance in the care and treatment of the patient. This way, the respect for the confidentiality of the data is also kept in this circumstance³⁹.

According to this list of documents, the direct interest of the patient (in the scope of the health team) or, in the case of third parties, the right of those to whom the information implies immediate or prior risk requires perhaps swift intervention in order to prevent further damage, as it is in the

case of individuals known to be at risk of contamination by unprotected sex. Even so, the ideal is to encourage patients to take the initiative to inform their partners, avoiding thereby the disclosure of secrecy. This disclosure will only be made without the patient's consent if it is established that with his or her conduct and resistance, the patient is endangering another person's integrity, which is a criminally punishable conduct, considering the wilful intention to contaminate other people or the gross negligence of the act .

Other legal situations that exempt professionals from the duty of confidentiality concerns children and adolescents maltreatment, an increasingly diagnosed condition, to which health professionals' attention and action are essential in order to prevent the minor's return to the cycle of violence, which often occurs in his or her own residence. To prevent such events, the Child and Adolescent Statute (abbreviated ECA in Brazil - Estatuto da Crianca e Adolescente) determines, in its article 13: *The cases of suspected or confirmed abuse against children or adolescents will obligatorily be notified to the local Tutelary Council , without prejudice to other legal provisions.* And further, in Article 245, the statute characterises as administrative infractions, among other situations: *the doctor, teacher or responsible for health care establishment, primary education school, preschool or kindergarten, who refrain to communicate to the competent authority, cases of suspected or confirmed children or adolescent maltreatment. Penalty - fine of three to twenty reference wages and double that amount in case of repetition* ⁴⁰.

Similar measure was also included in the the Elderly Statute, intended to curb abuse against this group, also of particular vulnerability. In order to identify such cases, a cautious investigation, by thorough examination and anamnesis. Despite the possibility of harm caused by frivolous accusations, the legal provision supports the communication of based suspicions, in order to avoid any crime of slander. Once the evidence is verified then those patients should not be lost from sight, considering that they are at risk where they are. It may even be necessary to maintain the patient in the health unit for social preventive issues pending action of the Tutelary Council or prosecutor. In places where the tutelar council doesn't exist, the communication of suspected maltreatment related to the minor patient should be made to the Justiça da Infância e da Juventude (Justice of Childhood and Youth) or to the State prosecutor ⁴¹⁻⁴⁴, accounting for just cause for breach of confidentiality.

In turn, the notifiable diseases, another hypothesis of legal breach of confidentiality, are contained in the Ordinance 1,271 / 2014, of the Ministry of Health ⁴⁵. It is a criminal offence to not communicate those diseases to the competent public institutions, in accordance with Article 269 of the Brazilian Criminal Code: *If the doctor fails to report notifiable diseases to the public authority : Penalty - detention of six (6) months to two (2) years and a fine* ²⁸. The compulsory character, in this case, represents an exceptional restriction of the interest of the individual in favour of public health and security, since it aims at the possible need for action in the area of public health policies.

Other hypothesis of breach of confidentiality admitted by the jurisprudence are the judicial request of medical records and the need to defend the professional, within the limits of what is essential to these purposes, according to the CFM Resolution 1,605 / 2000 ⁴⁶.

Post mortem secrecy

Finally, we must point out that the duty of secrecy does not cease with the death of the patient - which would open space for debate on the ethical appropriateness of the current regulatory requirement to record the cause of death on the death certificate provided by notaries, despite the undeniable importance of such registration to public health - or because it is public knowledge (Article 73 of the CEM, from 2010 ²¹).

As access to medical records after the patient's death, the aforementioned article 77 of the CEM (Abbreviation of Código de Ética Médica in Brazil - Code of Medical Ethics) was changed by the CFM Resolution 1,997 / 2012, with the intention of including in its latest redaction the following prohibition: *To provide information to insurance companies on the circumstances of the death of the patient in your care, besides those contained in death certificates* ⁴⁷. The previous text was more flexible in terms of family authorisation when it prohibited the provision of *information to insurance companies about the circumstances of death of the patient in your care, besides those contained in death certificates, except by express consent of the patient's legal representative* ²¹. As seen, it is not unreasonable to consider that the very mention of the cause of death on the public certificate already is a disclosure of data that maybe the patient - who owns the secrecy and is favoured by it - did not want to see disclosed.

In this context, however, it is essential to highlight the recent CFM Recommendation 3/2014, which, under the strength of the preliminary injunction in the minutes of public civil action 26.798-86.2012.4.01.3500, filed by federal prosecutors of Goiás (a Brazilian federative state), with interposition of an interlocutory appeal, complied with the provisions below: *Recommend to medical professionals and medical, clinical, ambulatory or hospital treatment institutions in order to: a) provide, when requested by the surviving spouse / partner of the dead patient, and subsequently by the next in line legitimate successors of the patient, or relatives up to the fourth degree, the medical records of the deceased patient: Provided that the family bond has documentary proof and observed the order of heredity; b) inform patients about the need for an explicit statement of objection to the disclosure of their medical records*⁴⁸.

It must be recognised that, in most cases, patients have no reason to hide their medical records from their friends and family, and that access to such a documentation has legal repercussions when there are doubts, for example, about the adequacy of the medical care of the patient, so the absolute secrecy would in this case be paradoxically contrary to the interests of the patient. However, given that medical confidentiality is a strictly personal right of the patient⁴⁹, the rule should be the post mortem preservation, always preceded by questioning the patient, at the time of his or her internment, on whether or not to allow the family to have access to medical records. Considering the way that item b was formulated, it appears that secrecy about the medical record of a dead patient is an exception, which in itself would raise a doubt, with psychological repercussions, for the family of the patient as they wouldn't be sure if they were acting according to the patient's wishes or not. Perhaps the patient had wished to avoid this uncertainty. Thus, it is more relevant to affirm the secrecy of medical records and their very personal character as a rule, except for a previous consultation with the patient about who would be allowed to authorise access to the patient's medical records, in case of loss of consciousness or post mortem.

Final considerations

Secrecy is a patient's right and a duty of the professional, especially when it comes to interpersonal relations in healthcare. The guarantee of confidentiality allows for a more autonomous ex-

ercise of diversity and individuality, by protecting against external pressures which could eventually be coercive, aiming at equalisation of the majority or even the minority which are representative of the social environment. Only with effective respect to medical confidentiality will it be possible, in many cases, to have a consent that is in fact free, after due explanation, leaving solely to the patient the judgement of his or her own circumstances without fear of the repercussion that their personal health decisions may have on their environment.

Everybody who has access to personal data about patients should keep the information confidential. This applies both to the professional environment and to the research and teaching universe. Secrecy must be kept, inclusive of and as far as possible - that is, safeguarding the cases of risk to life or of serious risk to the integrity - in the case of a patient who is a minor but who has the competence to conduct herself or himself according to their own initiative.

This is because secrecy, in the legal framework, is associated with the constitutional rights of privacy, recognised as fundamental in Brazilian law, following the example of human rights at international level and with influence on the infra-constitutional legislation, including the deontological codes. Exceptions to the duty of secrecy are specific, consisting, according to ethical and legal provisions, of the risk of death to oneself or others as well as legally stipulated cases, such as notifiable diseases and suspicions of abuse against incompetent or particularly vulnerable individuals.

It should be remembered also that the medical record belongs to the patient, and the health unit works only as a custodian of the record. Thus, the access to those records should not be franchised to insurance companies or other health professionals unrelated to the treatment, nor the family, unless the patient, when able, authorises it. This decision is up to their legal guardians in the case of incompetent patients. Finally, the professional duty of secrecy does not end with the death of the patient or because it is a public fact or regards a public person, although one can discuss the easing of access, when expressly authorised by the patient or in the case of suspicion of poor professional practice which intervened in the cause of death.

From all the above, it is concluded that, with respect to the patient, the guarantee of secrecy works not only as a factor to stimulate participation in medical treatment, due to the patient's trust in

the professionals, but also as a space for the most reliable manifestation of autonomy, representing a protective mechanism for the very exercise of freedom. This is because patients, confident that their medical data will not be disclosed except by their

permission, feel freer to express their peculiarities and their particular ways of thinking, making their decisions on health matters without fear of judgment or the external repression about the most private aspects of their personality.

References

1. Quintana, M. Espelho mágico. Rio de Janeiro: Globo; 2005. Da descrição [poema].
2. Pessini L, Barchifontaine CP. Problemas atuais de bioética. 5ª ed. São Paulo: Centro Universitário São Camilo/Loyola; 2000.
3. França GV. Comentários ao Código de Ética Médica. 4ª ed. Rio de Janeiro: Guanabara Koogan; 2002.
4. Gracia D. Pensar a bioética: metas e desafios. São Paulo: Centro Universitário São Camilo/Loyola; 2010.
5. Francisconi CF, Goldim JR. Aspectos bioéticos da confidencialidade e privacidade. In: Costa SIF, Oselka G, Garrafa V, organizadores. Iniciação à bioética. Brasília: Conselho Federal de Medicina; 1999. p. 269-84.
6. Fortes PAC. Ética e saúde: questões éticas, deontológicas e legais, tomada de decisões, autonomia e direito dos pacientes, estudo de casos. São Paulo: EPU; 1998.
7. Carvalho JCM. Responsabilidade civil médica. 3ª ed. Rio de Janeiro: Destaque; 2002.
8. Cunha L, Patrício ZM. Confidencialidade e privacidade em planos de saúde. Rev. Bioética. 2008;16(1):141-54.
9. Abreu CBB, Fortes PAC. Questões éticas referentes às preferências do paciente em cuidados paliativos. Rev. bioét. (Impr.). 2014;22(2):299-308.
10. Costa Jr. PJ. O direito de estar só: tutela penal da intimidade. 2ª ed. São Paulo: RT; 1995.
11. Brasil. Conselho Nacional de Saúde. [Internet]. Resolução nº 466, de 12 de dezembro de 2012. [acesso 22 dez 2014]. Disponível: <http://conselho.saude.gov.br/resolucoes/2012/Reso466.pdf>
12. Neves MCP, coordenadora. Comissões de ética: das bases teóricas à atividade quotidiana. 2ª ed. Coimbra: Gráfica de Coimbra; 2002.
13. American Academy of Pediatrics. Committee on Bioethics [policy statement]. Informed consent, parental permission, and assent in pediatric practice. Pediatrics. 1995;95(2):314-7.
14. Canadian Pediatric Society. [Internet]. Bioethics Committee. Treatment decisions for infants and children. CMAJ. 1986; [acesso 22 dez 2014];135(5):447-8. Disponível: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1491550/pdf/cmaj00125-0033.pdf>
15. Rowine HB. Task Force on Pediatric Research, Informed consent and medical ethics. Pediatrics. 1976;57(3):414-6.
16. Sigman G, Silber TJ, English A, Epner JE. Confidential health care for adolescents: position paper of the Society for Adolescent Medicine. J Adolesc Health. 1997;21(6):408-15.
17. Taquette SR. Conduta ética no atendimento à saúde de adolescentes. Adolesc Saude. 2010;7(1):6-11.
18. Saito MI, Leal MM, Silva EV. A confidencialidade no atendimento à saúde de adolescentes: princípios éticos. Pediatría. 1999;21(2):112-6.
19. Leone C. A criança, o adolescente e a autonomia. Bioética. 1998;6(1):51-4.
20. Huneus A. Ética, sexualidad y adolescencia. Medwave. [Internet]. 2002 [acesso 21 ago 2015];2(8):e1291. Disponível: <http://www.medwave.cl/link.cgi/Medwave/Congresos/2002sogia1/1291>
21. Conselho Federal de Medicina. [Internet]. Resolução CFM nº 1.931, de 17 de setembro de 2009. Aprova o Código de Ética Médica. 2009 [acesso 22 dez 2014]. Disponível: <http://www.portalmédico.org.br/novocodigo/integra.asp>
22. Conselho Federal de Medicina. [Internet]. Resolução CFM nº 1.246, de 8 de janeiro de 1988. 1988 [acesso 22 dez 2014]. Disponível: http://www.portalmédico.org.br/resolucoes/cfm/1988/1246_1988.htm
23. Torreão L, Villas-Bôas ME. Aspectos ético-legais na consulta pediátrica. In: Silva LR, organizador. Diagnóstico em pediatria. Rio de Janeiro: Guanabara Koogan; 2009. p. 54-62.
24. Torreão L, Villas-Bôas ME. Aspectos éticos e legais na emergência. In: Silva LR, Mendonça DR, Moreira DEQ, organizadores. Pronto atendimento em pediatria. vol. 1. 2ª ed. Rio de Janeiro: Guanabara Koogan; 2006. p. 180-96.
25. Organização das Nações Unidas. [Internet]. Resolução 217 A (III). Declaração Universal de Direitos Humanos, 1948. [acesso 22 dez 2014]. Disponível: <http://unesdoc.unesco.org/images/0013/001394/139423por.pdf>
26. World Medical Association. [Internet]. International Code of Medical Ethics. 2006 [acesso 23 dez 2014]. Disponível: <http://www.wma.net/en/30publications/10policies/c8/index.html>

27. Brasil. Senado Federal. [Internet]. Constituição da República Federativa do Brasil, de 5 de outubro de 1988. Brasília: Diário Oficial da União, v. 126, nº 191-A, p. 1-32, 5 out 1988. Seção 1. 1988 [acesso 23 dez 2014].
Disponível: http://www.planalto.gov.br/ccivil_03/constituicao/constituicaocompilado.htm
28. Brasil. Presidência da República. [Internet]. Decreto-lei nº 2.848, de 7 de dezembro de 1940. Código Penal Brasileiro. 1940 [acesso 23 dez 2014].
Disponível: http://www.planalto.gov.br/ccivil_03/decreto-lei/Del2848.htm
29. Brasil. Presidência da República. [Internet]. Decreto-lei nº 3.689, de 3 de outubro de 1941. Código de Processo Penal. 1941 [acesso 23 dez 2014].
Disponível: http://www.planalto.gov.br/ccivil_03/decreto-lei/del3689.htm
30. Brasil. Presidência da República. [Internet]. Lei nº 10.406, de 10 de janeiro de 2002. Institui o Código Civil. 2002 [acesso 23 dez 2014].
Disponível: http://www.planalto.gov.br/ccivil_03/leis/2002/l10406.htm
31. Brasil. Presidência da República. [Internet]. Lei nº 5.869, de 11 de janeiro de 1973. Institui o Código de Processo Civil. 1973 [acesso 23 dez 2014].
Disponível: http://www.planalto.gov.br/ccivil_03/leis/l5869.htm
32. Conselho Federal de Enfermagem. [Internet]. Resolução Cofen nº 311, de 8 de fevereiro de 2007. Aprova a Reformulação do Código de Ética dos Profissionais de Enfermagem. 2007 [acesso 23 dez 2014]. Disponível: <http://se.corens.portalcofen.gov.br/codigo-de-etica-resolucao-cofen-3112007>
33. Conselho Federal de Fisioterapia e Terapia Ocupacional. [Internet]. Resolução nº 424, de 8 de julho de 2013. Estabelece o Código de Ética e Deontologia da Fisioterapia. 2013 [acesso 23 dez 2014]. Disponível: <http://www.coffito.org.br/site/index.php/fisioterapia/codigo-de-etica.html>
34. Brasil. Código de ética do/a assistente social. Lei 8.662/93 de regulamentação da profissão. 10ª ed. rev. e atual. Brasília: Conselho Federal de Serviço Social; 2012.
35. Organização das Nações Unidas para a Educação, Ciência e Cultura. [Internet]. Declaração Universal sobre Bioética e Direitos Humanos. Paris: Unesco; 2006 [acesso 23 dez 2014]. Disponível: <http://unesdoc.unesco.org/images/0014/001461/146180por.pdf>
36. Beauchamp TL, Childress JF. Princípios de ética biomédica. São Paulo: Loyola; 2002. p. 26, 543.
37. Conselho Federal de Medicina. [Internet]. Resolução CFM nº 1.359, de 11 de novembro de 1992. (Revogada pela Resolução CFM nº 1.665/2003). 1992 [acesso 23 dez 2014]. Disponível: http://www.portalmédico.org.br/resolucoes/cfm/1992/1359_1992.htm
38. Associação Médica Mundial. Declaração de Madrid. 1987. [acesso 28 ago 2015]. Disponível: http://www.malthus.com.br/mg_total.asp?id=157#set
39. Conselho Federal de Medicina. [Internet]. Resolução CFM nº 1.665, de 7 de maio de 2003. Dispõe sobre a responsabilidade ética das instituições e profissionais médicos na prevenção, controle e tratamento dos pacientes portadores do vírus da SIDA (Aids) e soropositivos. 2003 [acesso 23 dez 2014]. Disponível: http://www.portalmédico.org.br/resolucoes/cfm/2003/1665_2003.htm
40. Brasil. Presidência da República. [Internet]. Lei nº 8.069, de 13 de julho de 1990. Dispõe sobre o Estatuto da Criança e do Adolescente e dá outras providências. 1990 [acesso 23 dez 2014]. Disponível: http://www.planalto.gov.br/ccivil_03/leis/l8069.htm
41. Cury M. Estatuto da criança e do adolescente anotado. 3ª ed. São Paulo: Editora Revista dos Tribunais; 2002.
42. Cury M, Silva AFA, Mendez EG, coordenadores. Estatuto da criança e do adolescente comentado: comentários jurídicos e sociais. 5ª ed. São Paulo: Malheiros; 2002.
43. Elias RJ. Comentários ao estatuto da criança e do adolescente. 2ª ed. São Paulo: Saraiva; 2004.
44. Tavares JF. Comentários ao estatuto da criança e do adolescente. 5ª ed. Rio de Janeiro: Forense; 2005.
45. Brasil. Ministério da Saúde. [Internet]. Portaria nº 1.271, de 6 de junho de 2014. Define a Lista Nacional de Notificação Compulsória de doenças, agravos e eventos de saúde pública nos serviços de saúde públicos e privados em todo o território nacional, nos termos do anexo, e dá outras providências. [acesso 21 maio 2015]. Disponível: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2014/prt1271_06_06_2014.html
46. Conselho Federal de Medicina. [Internet]. Resolução CFM nº 1.605, de 15 de setembro de 2000. 2000 [acesso 23 dez 2014]. Disponível: http://www.portalmédico.org.br/resolucoes/CFM/2000/1605_2000.htm
47. Conselho Federal de Medicina. [Internet]. Resolução CFM nº 1.997, de 10 de agosto de 2012. Altera a redação do artigo 77 do Código de Ética Médica, aprovado pela Resolução CFM nº 1.931, de 17 de setembro de 2009. 2012 [acesso 23 dez 2014]. Disponível: http://www.portalmédico.org.br/resolucoes/CFM/2012/1997_2012.pdf
48. Conselho Federal de Medicina. [Internet]. Recomendação CFM nº 3, de 28 de março de 2014. 2014 [acesso 23 dez 2014]. Disponível: http://portal.cfm.org.br/images/Recomendacoes/3_2014.pdf
49. Bittar CA. Os direitos da personalidade. Rio de Janeiro: Forense; 2001.

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