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Privacy and confidentiality in therapeutic process: contributions from bioethics

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Abstract

This study discusses privacy and confidentiality in the areas of medicine and, particularly, mental health, arguing that the rights and duties encompassed by the two principles should be practiced in compliance to bioethics. Psychic knowledge was adopted to broaden our understanding regarding the importance of confidentiality in the therapeutic process. It emphasizes the connection between the technological and media changes of the last decades and the risk of compromising medical confidentiality, which would definitely affect the patient's trust concerning information privacy. Finally, the text reflects on the relevancy of ethical support for health professionals, especially in cases where they must decide on whether or not to breach confidentiality.

Keywords: Bioethics. Privacy. Confidentiality. Ethics, medical. Mental health. Medicine.

Resumo

Privacidade e confidencialidade nos processos terapêuticos: presença da fundamentação bioética

Este estudo revisa a caracterização dos princípios da privacidade e da confidencialidade em conexão com áreas da medicina em geral e da saúde mental em especial, propondo que a prática dos direitos e deveres envolvidos com os dois princípios deve ser preservada nos moldes ditados pela bioética. Privilegia-se a abordagem do saber psíquico, a fim de ampliar a compreensão da particular importância da confidencialidade nos processos terapêuticos. Salienta-se a conexão entre as mudanças tecnológicas e midiáticas ocorridas nas últimas décadas e o risco de comprometimento do sigilo médico, cuja quebra afetaria em definitivo a confiança do paciente quanto ao resguardo da privacidade de suas informações. Ao final, são feitas reflexões sobre o valor do suporte ético ao profissional de saúde, principalmente nos casos excepcionais em que lhe cabe tomar decisões sobre quebra de confidencialidade.

Palavras-chave: Bioética. Privacidade. Confidencialidade. Ética médica. Saúde mental. Medicina

Resumen

Privacidad y confidencialidad en los procesos terapéuticos: presencia de fundamentos bioéticos

Este estudio analiza la caracterización de los principios de privacidad y confidencialidad relacionados con los campos de la medicina en general y la salud mental en particular, proponiendo que la práctica de los derechos y deberes respecto a estos dos principios debe preservarse de la manera defendida por la bioética. El enfoque del conocimiento psíquico se privilegia con el fin de ampliar la comprensión de que la confidencialidad es importante en los procesos terapéuticos. Se destaca la relación entre los cambios tecnológicos y mediáticos que se han producido en las últimas décadas y el riesgo de comprometer el secreto médico, cuya violación afectaría definitivamente la confianza del paciente respecto a la privacidad de su información. Por último, se reflexiona sobre el valor del apoyo ético a los profesionales de la salud, sobre todo en los casos excepcionales que involucran su toma de decisión respecto a la violación de confidencialidad.

Palabras clave: Bioética. Privacidad. Confidencialidad. Ética médica. Salud mental. Medicina.

Update

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When reviewing the issue of privacy and confidentiality in situations related to medicine and especially mental health, ethical approaches are highlighted as paramount for implementing processes that ensure patient privacy and preserve trust between health professionals and patients. More than a technique, every health practice is invariably ethical, as highlighted by Gracia [1]. Thus, rights and duties involved in privacy and confidentiality must be preserved according to ethics. Allen [2] provides a similar understanding by stating that bioethics defines privacy as a moral or value claim, although it is also viewed as a fact or legal right by other authors.

This study undertakes promoting the continuity of confidentiality and privacy based on Hippocrates' patient-centered model of the ethical procedure. It seeks to bring this model into current reality, in which such principles are threatened, for example, by the misuse of social media or how easily technology allows for disclosing confidential data.

Intimacy and the Hippocratic conception

As Scarton [3] states, people look for qualified professionals to help them whenever there is an urgent need to recover from a morbid condition or repair anatomical injuries. The issue seems to have been substantiated by Hippocrates, in Ancient Greece, but authors such as Malin, Emam and O'Keefe [4] argue that privacy and confidentiality were already considered legal obligations and ethical duties in medicine long before the ancient Greeks.

But the most obvious fact is that, after Hippocrates pronounced that which would later become a solemn oath to all doctors—*everything I may bear witness to or hear, either professionally or privately, that concerns their human intimacy and must, therefore, not be disclosed, I shall keep secret from all and everyone—the internal, private and moral character of the doctor's professional responsibility* [5] was thus defined, according to Loch, who quoted and commented on the aforementioned excerpt. To this day, medicine safeguards the importance of the *Hippocratic oath*, adopting it as an ethical foundation regarding privacy and confidentiality. Attention to these principles must, thus, be constantly and continuously renewed by studies, so that patient decision-making on data exposure is always respected.

Secrecy and trust

Privacy and confidentiality may differ but are mutually and deeply related. Broadly speaking, privacy imposes a limit to the intrusion on patient privacy by third parties, and, as Loch states [6], it is up to the latter to determine such a limit. Besides this intimacy, one must consider the physical space surrounding the patient and their body, creating a scenario in which their secrets or information are securely protected. For Winslade [6], whether from an ethical or legal perspective, privacy refers to one's right to intimacy, as well as limiting third-party access to their mind or body via physical contact or the disclosure of one's thoughts and feelings.

Beauchamp and Childress [7] draw from another theoretical perspective when affirming that, among various interpretations and definitions, some authors confuse privacy with the right to control intimacy. Rather than a normative right, the authors understand privacy as a status or condition of physical or informational inaccessibility, encompassing bodily products and objects closely connected to the person and their intimate, personal, or professional relations.

Kottow [8] argues similarly by stating that personal information derived from the patient's words or physical examination cannot be accessed by third parties unless sharing is requested or authorized by the patient. To better visualize this non-random sharing aspect, privacy can be understood as a line separating the public and private spheres regarding a specific individual. Disagreements concerning confidentiality abound in the search for a philosophical contribution to the debate. França [9] states that absolutists advocate for the imposition of total secrecy in all cases and any situation; abolitionists, in turn, claim that secrecy is a farce between patient and doctor; while the eclectic, intermediate, or relativists consider that secrecy, for greater social reasons, should not be so radically defended.

For Loch [5], confidentiality is an implicit guarantee given to the patient by health professionals or institutions. Dantas [10] reminds us, however, of contractual confidentiality, such as the information confidentiality commitment term and authorization term for the use of health information. In any case, such confidentiality usually guarantees that information or confidences are not exposed or, at least, are not exposed without the patient's authorization.

The term confidentiality, at its very origin, refers to the idea of trust, implying prior either tacit or written agreement of a trust relationship, functioning as a norm that, when not complied with, constitutes a violation, similar to the transgression of a law. Thus, confidentiality can be viewed as a right. Francisconi and Goldim [11] highlight that information and confidences, as well as test results and diagnostic or therapeutic treatments performed, constitute property of the patient, with health professionals and institutions constituting only their faithful depositaries, and therefore unable to use them freely.

The genesis of privacy

Besides its origins, knowing its genesis is also paramount as a human process, during which one can perceive the role of secrecy in the face of human fragility and therefore the responsibility for the breach of trust by one of the parties. Drawing on psychoanalysis, such as Anna Freud's [12] writings on childhood, confidentiality has its source in the human process of keeping and sharing secrets. It begins naively in childhood, when being able to say you have a secret matters more than the secret itself; as an initial phase of close contact between the child and the Other, this closeness means far more than the secret itself. Once childhood gives way to pre-adolescence after the age of 7, changes take place in this scenario.

During adolescence, secrets acquire value in themselves and correspond to life processes, which are generally affective and sexual. At this time, the breach of secrecy results in psychological and emotional damages that can prove quite relevant. Besides establishing trust and more intimate relationships, sharing a secret in adolescence gives rise to a more developed sense of self, which Jung [13] sees as the core of the personality, an organizer of psychic processes that integrates and balances aspects of the unconscious, providing unity and stability to the human personality.

Inadequate development during these two initial stages of the secret results in an adult reluctant to share their fantasies, desires, and thoughts, fearing feeling discriminated against, ashamed, and disappointed. Generally, however, people would rather share their intimacy with those they trust, as a way to achieve emotional stability or relieve pressure from feelings and thoughts.

At any age group, confidentiality must be preserved by those around the individual—family, friends, professionals, or nonprofessionals—, a principle that also applies, according to Francisconi and Goldim [11], if the person has already died, is a public figure, or is unconscious. The authors stress that confidentiality and privacy must exist within an atmosphere of veracity, trust, and fidelity, extending to all regardless of their degree of understanding and mental health.

Characteristic and justification

When studying the binomial privacy/confidentiality, ethics emerges as a constant factor that permeates their characterizations and justifications. Thus, respect for privacy and confidentiality is characterized as a *prima facie* duty, referring to the fulfillment of moral obligations that must be followed as long as they are not superseded by another duty of equal or greater importance.

Moving from the individual to the collective, França [9] recalls that the medical sciences, as public services, can occasionally value the collective interest over the individual. In such situations the State assumes the role of a public health manager, manipulating people's life and health as if a common good, consequently weakening the concept of confidentiality.

Francisconi and Goldim [11] characterize privacy and confidentiality as bioethical principles encompassing all health professionals,

professors, and administrative staff, as well as related institutions. This ethical scope is well emphasized by the authors, who see privacy and confidentiality as a commitment from the whole to the whole. Such principles are also regarded as patient rights and societal achievements.

This assertion recalls Kaye [14], who believes rights define civil society. Importantly, while presenting itself as a social phenomenon, privacy will be perceived according to how society chooses to codify this concept in policy and law, an issue studied by Silva, Araújo, and Nascimento [15]. As Malin, Emam and O'Keefe [4] point out, it is up to legislation and politics to codify the rights and needs of privacy management within the biomedical field. The characteristics proposed above mix duties and rights concerning the medical-institutional part and the patients. Loch's [5] study supports this assertion by showing that the professional's mandatory secrecy and the patient's right to have their information kept private confer a dual nature to confidentiality, turning it into a right-duty. The author also emphasizes that confidentiality presupposes information both voluntarily and consciously provided by rational, informed, and free individuals; that is, in the full exercise of their autonomy as a bioethical principle.

França [9] points out that privacy is justified by promoting security in intimate and social coexistence. Francisconi and Goldim [11], in turn, argue that confidentiality is justified by belonging to a set of individual and property rights, having an instrumental value (with several purposes), and presupposing the realization of intimate and essential social relations for the expression of personal freedom.

They add that confidentiality can be essential to the therapeutic process, specifically for mental disorders, in which the role of information inviolability is directly linked to the results of the process, as it is part of a scenario where fears, anxieties, guilt, and hostile feelings—as well as stigmatization, shame, unconfessed desires, among others—are exposed by the patient to the psychotherapist.

For Loch [5], confidentiality is also justified by respecting the nature of the right to privacy, as well as being a professional duty. It also minimizes or extinguishes patients' fear of negative social or economic repercussions generated by their health status. This aspect is further argued by Beauchamp and Childress [7], who speak of the instrumental and consequential value as a justification for confidentiality. They highlight how paramount confidentiality becomes in this regard, since patients, aiming to recover or maintain their health, define the level of sharing or choose to give up part of their privacy, meaning that the absence of confidentiality would lead them not to seek treatment or to poor treatment adherence.

França [9] finds confidentiality justifiable because it protects people's reputation and credibility, thus introducing an aspect related to respect for others, which is interesting for bioethical studies. The author connects the value of confidentiality to its Hippocratic origins, of a sacred, transcendent, confessional, and religious nature, and therefore inviolable.

Morais [16], in turn, emphasizes the public interest in preserving confidentiality, which would be accepted by civil authorities. Durand's [17] justification is seemingly simple—since confidentiality is considered a good medical practice—, but involves a whole ethical and technical universe from that professional area. Scarton [3] points out that patient information must be kept confidential for the benefit of the confidant, to uphold social coexistence and the very credibility and viability of healthcare professionals.

Confidentiality in therapeutic processes

Despite its relevance across all biomedical aspects, the issue of privacy and confidentiality becomes fundamental when treating mental illnesses. This is supported by Loch, Gauer, and Kipper [18], who states that the relationship between psychotherapist and patient in psychiatry/psychology contains special characteristics due to the patient's vulnerability. According to the authors, psychiatrists and psychologists, by having access to their patients' privacy, can infringe on their most elementary human rights or manipulate their conscience.

By outlining the therapeutic process, one observes that confidentiality develops over

a few steps. The patient's initial movement of empathy is followed by psychoanalytic rapport, which will make way for the therapist to access their intimacy and share in it. A transference mechanism begins, bringing up the patient's repressions, complexes, and traumas, from which evolves the psychotherapeutic process. A bond is established from working on elements that should be known only to the patient and the therapist, unless new sharing is admitted by the treated subject, in an atypical case. In essence, the therapeutic process presumes a condition of privacy in which permission—always voluntary and born out of trust—for knowledge of intimate factors is given by the patient, implying that such information shall remain secret. This schematic asserts the value of confidentiality and ethics in mental health treatment.

Mental health should not supersede physical health. From a psychiatric and pragmatic perspective, a healthy mind represents a state of psychological well-being, an ability to adapt to different relational and social situations within a community, and a harmonious coexistence with the positive rulings of legal ordinances [19]. As such, one must consider the importance of providing therapeutic support to patients and, consequently, paying attention to the confidentiality inherent to this process, thus allowing it to be fully achieved.

Gestalt therapy, psychodrama, and logotherapy also recognize the relationship of trust between patient and therapist as paramount to enable an autonomous identity and a harmonious development of the psychic sphere. During therapeutic work, patients reveal their most personal side and share their intimacy because they trust in the therapist's ability to preserve information confidentiality. Said professional would be able to confirm the other, allowing their patient to create an identity, a structured ego. Even psychopathology situations, as Fantin and Friedman [20] argue, presuppose an organization and translate into ethical dilemmas. Thus, the therapist's worldview and their ethical and bioethical conceptualization of the person are what separate disease from suffering.

In other words, describing the types of privacy proposed by bioethicists may give greater visibility to the relevance of confidentiality in therapeutic processes.

Types of privacy

As principles based on the ethics of relations between individuals, privacy and confidentiality feature in the Code of Medical Ethics of the Federal Council of Medicine (CFM), Chapter I, item XI as follows: *the physician shall maintain confidentiality regarding the information learned in the performance of their duties, except in cases provided for by law* [21]. According to Article 9 of the *Universal Declaration on Bioethics and Human Rights* (UDBHR), issued by the United Nations Educational, Scientific, and Cultural Organization (Unesco), *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* [22].

Typification of the binomial privacy/confidentiality would be presented by bioethicists in several versions to broaden the understanding of the UDBHR general guidelines and help health professionals abide to such guidelines. The five topics proposed below summarize definitions and information from various authors. The choice was arbitrary and limited to the context of health care relations, and should be considered as purely didactic.

Bodily privacy

Invasion of bodily privacy would manifest through the physician's intimate contact or touching of the patient's naked body; manipulation, either invasive or not, of the patient's body parts; and the permission given by the doctor for third parties to touch or observe the patient, either in person or virtually, during a procedure without their express authorization [23].

Informational privacy

Only the patient can determine whether all or any of the information provided may be

transferred to third parties, as well as how and when this should be done. The UDBHR guidelines [22] dictates that the information and studies presented in the Report of the Confidentiality Committee of the International Psychoanalytic Association (IPA) [24] be used within the limits of their intended disposition and never without the patient's consent.

To some people, information about their health status can be an extremely intimate, personal matter that is directly linked to their sensibility. Information collected by physical examination or anamnesis can be viewed as an extension of the patient's mind or body. Thus, informational privacy can be understood as anonymity or secrecy of sorts, regardless of the information collected being real or imaginary—a valid hypothesis in cases of psychotherapy, for example, which intends to address the patient's imaginary and the resulting data is extremely relevant.

Proprietary privacy

Proprietary privacy relates to everything a person owns. In health care, this privacy is violated by the unauthorized use of biological material (blood, saliva, urine, semen, hair, bone marrow, etc.) or of the patient's genetic code. Advancements in molecular research has allowed for fast and relatively cheap whole genome sequencing, retrieving information on the protein variants encoded in a person's genome and those that influence the emergence of various diseases or syndromes. Evidence shows that breaches of privacy in this field may affect the patient, their immediate family, and even their future generations [25].

Physical-spatial privacy

In this context lies one's wish to limit social contact, that is, to create an imaginary field around themselves, which could be understood as an extension of their being, a personal space. One such example is when a patient refuses examination by medical students, does not allow cameras to monitor their hospital room, or refuses to have their therapy session recorded, understanding the space of the session as exclusively theirs and of their therapist. This type of privacy concerns the degree of physical accessibility a person wants to grant to others [26], an understanding that should be extended to the use of doctors' offices.

Psychological or psychic privacy

It involves protecting the individual's attitudes, beliefs, and values from disclosure or judgment by others. In psychotherapeutic treatment, establishing a rapport and transference process results in traumas, complexes, shame, and unconfessed desires, among other feelings and emotions of the patient concerning morality, religion, etc., being shared. As Silva Jr., Araújo, and Nascimento [15] stress, disclosure of such data could lead to stigmatization and discrimination by their immediate community. This issue is also detailed by article 11 of the UDBHR [22] and reflects a violation of human dignity, human rights, and fundamental freedoms.

Exceptions to confidentiality

Legal and normative support

Historically, the Hippocratic precept was so binding to the Greeks that it granted medicine a particular status from other professions, making Greek doctors legally unaccountable. The oath taken by the physician was solemn and sacred, defining *the internal, private and moral character of the professional responsibility of the Hippocratic physician* [27], as Loch recalls. This scenario, however, did not last indefinitely and the transformations of the post-Hippocratic societies called for the legal liability of health professionals and their patients concerning issues of privacy and confidentiality in medicine. Many privacy- and confidentiality-related aspects deserved legal protection or at least support from large organizations, either governmental or not, in different countries. As Kaye [14] highlights, currently, all legal documents of liberal democracies afford protection to individual privacy, being a defining aspect of civil society.

Although the respect for privacy and confidentiality included in CFM's Code of Medical

Ethics must be fully exercised by healthcare professionals and institutions, the exceptions contained therein must also be considered. By prohibiting physicians from disclosing facts known as a result of their profession, Article 73, Chapter IX of the code provides a complement: *except for due cause, legal duty, or written consent of the patient* [21]. In this event one may appeal to due cause, which França [9] understands as a relevant, noble reason of a moral, ethical, legal or social order, which allows an individual to not comply with a rule, based on a notion of need. According to the author, due cause would be something fair from the individual's subjective perspective (personal justice) or the community perspective (social justice), that is, dependent on the context and bound to the each one's conscience.

The following are given as due cause reasons within the therapeutic field:

- Information the professional deems fair to reveal, as Cohen and Marcolino [28] argue (keeping in mind the possible disagreement in opinion between professionals regarding the same patient, especially in mental health practices);
- The compelling possibility of physical and/or psychological damage to the patient's health and integrity and/or other identifiable and specific persons, including the risk of death;
- To care for the well-being and social security, given that the community wishes to be informed of highly probable potential dangers [29] for its own prevention and protection (with special attention to the possibility of discrimination and social rejection of patients suffering from mental afflictions regarding the remaining two items); and
- A real benefit resulting from it, as taught by Junkerman, Derse and Schiedermayer [30].

While the legislation aims to cover all possible exceptions to the guarantee of confidentiality in the medical profession, controversies arise, especially regarding people with mental disorders and in cases of patients undergoing therapy.

Privacy and confidentiality may, in principle, be derogated or abrogated where appropriate:

- Finding a framework for due cause and legal duty;
- Presenting a limitation regarding the proper exercise of autonomy, self-determination, and personal freedom, in the eyes of knowledge and professional power [31]. Take as an example a regression situation in which the patient is fragile and does not wish to exercise their autonomy, creating the need for another to decide for them. In such situations, the professional should exert caution and reflect that these cases may be transitory, not automatically justifying, therefore, the breach of confidentiality;
- A decline in competence, that is, the ability to judge and decide voluntarily and rationally about one's own matters [31], or reduced discernment in the responsible practice of civil life acts, a factor that would qualify the patient as either legally capable or incapable [32];
- Dependence on a legal representative [31];
- Emergency clinical conditions [17];
- Criteria for involuntary hospitalization or treatment;
- Severe inability to perform self-care, as Taborda [33] points out. The author recalls that, it is sometimes necessary to differentiate gestures of rebellion or individual affirmation from a youth counterculture that may refuse to shower, clip their nails, or get a haircut, from the organic or psychotic processes that prevent patients from observing their own bodily hygiene.

Although these definitions may be precise to a level, they remain questionable since the limits of the mental health field are imprecise. Besides, patients find themselves in a state of emotional fragility and psychic restructuring during the therapeutic process, aimed at coping with their limitations and suffering, which presupposes secrecy of what is revealed. Thus, secrecy has practical and symbolic importance in this type of treatment, and caution is recommended to avoid hasty decisions regarding derogations.

Current challenges

If there has always been a concern on the part of bioethics regarding aspects related to privacy and confidentiality, now there seems to be a

greater need for attention in face of a series of worldwide transformations. Chief among them the computerization of data recording brought about by the technological revolution and the introduction of new propaedeutic and therapeutic processes. Moreover, we have the race for professional or financial success using social media and the change in the concept of private and the private *versus* public relationship in a scenario where the boundaries of privacy become blurred by the constant activity on social networks and excessive exposure of personal lives online.

Given the broad consequences it entails, one of the changes that currently calls for further attention are patient charts and similar recordings. Hospitals now rely on digital medical records, which facilitates the contact of people outside the biomedical circuit with the data contained therein. Discussing such use of data, which in itself is undue since it is not authorized by patients, brings back considerations previously presented in this study, such as the consequential value of confidentiality regarding not sharing secrets [7], or the very credibility and viability of health professions [3]. Such factors warn us about the threat posed to confidentiality by the improper access to medical records.

Conversely, propaedeutic and therapeutic processes currently demand multidisciplinary involvement, especially in hospital admissions and surgical procedures, which means a greater number of people will have access to patient information [34]. There is no denying the care advantages of this type of involvement, but as Herranz-Rodríguez [35] states, it cannot be ignored that these professionals, obliged to secrecy by their respective deontological codes, must proceed with an ethically correct handling of the information to which they have access.

Technology makes countless devices available to health professionals. Recording, filming, accessing devices, communicating, disseminating, and sharing data are just some of the acts that, due to inattention, negligence, or bad faith, can be incorrectly performed by professionals, leading to a breach of patient confidentiality. The use of devices available to many health professionals undoubtedly improves care in itself, but they can also, either voluntarily or involuntarily, open doors for indiscreet, inappropriate, unethical and illegal behavior on social networks [36]. This brings us back to França's [9] considerations, who advocates the zeal for people's reputation and credibility, or those of Loch [5] about respecting the right to privacy. A brief search online makes it clear that this is an era in which information is seen as a collective good, reducing privacy to a lesser good.

Moreover, media appeals tempt professionals to skip stages of work, dedication, and study to seek success, professional recognition, or instant celebrity through the use of information or case reports that should be kept confidential. This situation is echoed in Bauman's [37] characterization of postmodernity as liquid, promoting fluid relationships and loss of sensitivity, in which the option for ethics is diluted.

Conflicts and reflections

In essence, every discussion on privacy and confidentiality revolves around ethical stances and choices of one human being towards another, given certain circumstances. Thus, evaluating exceptional situations in which the professional must decide whether or not to break patient confidentiality during the therapeutic process can reveal if they are making decisions that are closely related not only to their knowledge, but also to their conscience. It is clear that the ethical view helps in resolving issues.

Although decision-making regarding the breach of patient confidentiality is a fundamental part of the therapeutic process as a whole, it may involve extremely complex variables, especially for patients with mental disorders. Even when supported by legal guidelines, this breach of secrecy constitutes a decision connected not only to the doctor's or psychologist's knowledge and its reasonableness, but also to deep care and responsibility, since these decisions can indelibly compromise the rest of the patients' lives.

In several possible situations, the professional may be faced with decisions that affect patient autonomy, such as whether or not to disclose a contagious and dangerous disease that the patient insists on hiding from their family. Or face the dilemma of whether or not to denounce the

identity of a rapist revealed by the victim after arduous therapy based on trust. In this case, the patient would understand the act as a disrespect of their self-determination to remain silent, leading to social stigma [22] and insecurity.

One situation that generates particular challenges refers to people deemed incompetent under the law, as they are someone else's responsibility. In such cases, guardians may feel entitled to access information protected by medical confidentiality and may even try and demand greater transparency regarding the patient's psychological treatment. In case of a minor or a child, parent concern is understandable, yet the minor's right to privacy and trust in the professional must be considered. Importantly, a reasonable part of the psychological conflicts involving these patients could be directly related to the guardians themselves. This challenge demands that professionals find a balance between the importance of keeping the person responsible informed about the state of their incapacitated relative and the patient's development without, however, exposing their intimacy. As such, they must also consider the safety of the incapable in situations of vulnerability inside the family, as is the case of LGBTQIA+ youth who did not come out to their family members due to fearing (either justifiably or not) their reaction.

Regardless of the situation, breaching confidentiality means a definitive rupture of therapeutic ties with the patient, configuring a conflict between a beneficent decision (that is, the continuation of a necessary therapeutic treatment for the patient) and a non-maleficence act (since the seriousness of the reason suggesting the breach of confidentiality may involve significant harm to the patient or to others). Exacerbating the dilemma, professionals must be prepared to cross the terrain of uncertainty about the results generated by their decision, having no guarantees about them, since not even the predictions of due cause for breach of confidentiality are accurate. No less important is the professional's reflection on their own ability to decide, questioning the degree to which their subjectivity or ethics are interfering in their assessment and decision.

Final considerations

The high complexity surrounding the issue of breaking or derogating confidentiality in mental health treatment requires a great deal of caution and reflection from the therapist, as the answers may not always be covered by laws, guidelines, or psychological/psychiatric evaluations. The cases abound, but professionals will always be supported by bioethical reflection guided by universal principles, such as respect for the dignity of the person, their rights, and fundamental freedoms. Support for new decisions will always be available when guided by critical solidarity and cooperation, principles well described in bioethical studies. Acting as an ethical being, the health professional—and, in particular, the therapist—no longer helps their patient, but a fellow human being instead.

References

1. Gracia D. La confidencialidad de los datos genéticos. In: Gracia D, organizador. Ética y vida: ética de los confines de la vida. Santa Fé de Bogotá: Buho; 2003. p. 137-50.
2. Allen AL. Uneasy access: privacy for women in a free society. Totowa: Rowman and Littlefield; 1988.
3. Scarton RR. Violação do segredo profissional dos médicos: aspectos jurídicos e (bio)éticos. Âmbito Jurídico [Internet]. 19 jul 2019 [acesso 23 mar 2023]. Disponível: https://bit.ly/3mMecB0
4. Malin BA, Emam KE, O'Keefe CM. Biomedica data privacy: problems, perspectives, and recent advances. J Am Med Inform Assoc [Internet]. 2013 [acesso 23 mar 2023];20(1):2-6. DOI: 10.1136/amiajnl-2012-001509
5. Loch JA. Confidencialidade: natureza, características e limitações no contexto da relação clínica. Bioética [Internet]. 2003 [acesso 23 mar 2023];11(1):51-64. p. 56. Disponível: https://bit.ly/43BsZ2c

6. Winslade WJ. Confidentiality. In: Reicht WT, editor. Encyclopedia of bioethics: revised edition. New York: Macmillan; 2014. p. 494-501.
7. Beauchamp TL, Childress JF. Principles of biomedical ethics. New York: Oxford University Press; 2019.
8. Kottow MH. Introducción a la bioética. Santiago: Mediterraneo; 2005.
9. França GV. Segredo médico. In: Lana LR, Figueiredo AM, organizadores. Temas de direito médico. Rio de Janeiro: Espaço Jurídico; 2004. p. 367-88.
10. Dantas RA. O sigilo e o direito individual. In: Bandini M, Bonciani M, organizadores. Questões éticas na prática da medicina do trabalho: sigilo profissional e confidencialidade. São Paulo: ANAMT; 2017. p. 26-30.
11. Francisconi CF, Goldim JR. Aspectos bioéticos da confidencialidade e privacidade. In: Costa SIF, Oselka G, Garrafa V, coordenadores. Iniciação à bioética. Brasília: Conselho Federal de Medicina; 1998. p. 269-84.
12. Freud A. Infância normal e patológica. Rio de Janeiro: Guanabara; 1987.
13. Jung CG. O homem e seus símbolos. São Paulo: Harper Collins Brasil; 2016.
14. Kaye J. The tension between data sharing and the protection of privacy in genomics research. Ann Rev Genomics Hum Genet [Internet]. 2012 [acesso 23 mar 2023];13:415-31. DOI: 10.1146/annurev-genom-082410-101454
15. Silva DN Jr, Araújo JL, Nascimento EGC. Privacidade e confidencialidade no contexto mundial de saúde: uma revisão integrativa. Rev Bioét Derecho [Internet]. 2017 [acesso 23 mar 2023];40:195-214. Disponível: https://bit.ly/3MK0Tff
16. Morais Y. Segredo Médico. In: Hottois G, Parizeau M, editores. Dicionário de bioética. Lisboa: Instituto Piaget; 1998. p. 326-33.
17. Durand G. Introdução geral à Bioética: história, conceitos e instrumentos. São Paulo: Loyola; 2007.
18. Loch JA, Gauer GJC, Kipper DJ. Bioética, psiquiatria e estudante de medicina. In: Cataldo Neto A, Gauer GJ, Furtado NR, organizadores. Psiquiatria para estudantes de medicina. Porto Alegre: EdiPUCRS; 2013. p. 91-7.
19. Campbell RJ. Dicionário de Psiquiatria. Porto Alegre: Artmed; 2008.
20. Fantin JC, Friedman P. Bioética, salud mental y psicoanálisis. Buenos Aires: Polemos; 2009.
21. Conselho Federal de Medicina. Resolução CFM nº 2.217, de 7 de setembro de 2018. Aprova o Código de Ética Médica. Diário Oficial da União. Brasília, 7 set 2018.
22. Organização das Nações Unidas para Educação, Ciência e Cultura. Declaração universal sobre bioética e direitos humanos [Internet]. Brasília: Unesco; 2005 [acesso 23 mar 2023]. Disponível: https://bit.ly/3A39Poj
23. Pupulim JSL, Sawada NO. Privacidade física referente à exposição e manipulação corporal: percepção de pacientes hospitalizados. Texto Contexto Enferm [Internet]. 2010 [acesso 23 mar 2023];19(1):36-44. DOI: 10.1590/S0104-07072010000100004
24. Associação Psicanalítica Internacional. Relatório do Comitê de Sigilo da IPA 2018 [Internet]. London: IPA; 2018 [acesso 23 mar 2023]. Disponível: https://bit.ly/3UHRNBp
25. McGuire AL, Fisher R, Cusenza P, Hudson K, Rothstein MA, McGraw D *et al*. Confidentiality, privacy, and security of genetic and genomic test information in electronic health records: points to consider. Genet Med [Internet]. 2008 [acesso 23 mar 2023];10(7):495-9. DOI: 10.1097/GIM.0b013e31817a8aaa
26. Britto MT, Tivorsak TL, Slap GB. Adolescents' needs for health care privacy. Pediatrics [Internet]. 2010 [acesso 23 mar 2023];126(6):1469-76. DOI: 10.1542/peds.2010-0389
27. Loch JA. Op. cit. p. 56.
28. Cohen C, Marcolino JAM. Aspectos bioéticos em psiquiatria. In: Segre M, organizador. A questão ética e a saúde humana. São Paulo: Atheneu; 2006. p. 135-49.
29. Prodomo R. Segredo profissional. In: Lopes S. Dicionário de bioética. Aparecida: Santuário; 2001. p. 1012-5.
30. Junkerman C, Derse A, Schiedermayer D. Practical ethics for students, interns and residents: a short reference manual. Hagerstown: University Publishing Group; 2015.
31. Matos GEC. Aspectos jurídicos e bioéticos do consentimento informado na prática médica. Rev. Bioética [Internet]. 2007 [acesso 23 mar 2023];15(2):196-213. Disponível: https://bit.ly/3AmFqSh

32. Baú MK. Capacidade jurídica e consentimento informado. Bioética [Internet]. 2000 [acesso 23 mar 2023];8(2):285-95. Disponível: https://bit.ly/3GJN5gH

33. Taborda JGV. Psiquiatria legal. In: Taborda JGV, Prado-Lima P, Busnello EDA, organizadores. Rotinas em psiquiatria. Porto Alegre: Artes Médicas; 1996. p. 280-96.

34. Carvalhal GF, Poli MH, Clementel FK, Gauer GC, Marques GH, Silveira IG *et al*. Recomendações para a proteção da privacidade do paciente. Rev. bioét. (Impr.) [Internet]. 2017 [acesso 23 mar 2023];25(1):39-43. DOI: 10.1590/1983-80422017251164

35. Herranz-Rodríguez G. Comentarios al código de ética y deontología médica. Pamplona: Eunsa; 1995.

36. Martorell LB, Nascimento WF, Garrafa V. Redes sociais, privacidade, confidencialidade e ética: a exposição de imagens de pacientes no Facebook. Interface Comun Saúde Educ [Internet]. 2016 [acesso 23 mar 2023];13-23. DOI: 10.1590/1807-57622014.0902

37. Bauman Z. Cegueira moral: a perda da sensibilidade na modernidade líquida. Rio de Janeiro: Zahar; 2014.

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Alvaro Angelo Salles designed the project and built the initial bibliography. Luana Castelo expanded the research and made extensive contribution to the text. Both adapted the material and participated in each step of manuscript writing, leaving Alvaro Angelo Salles in charge of the final revision.

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