

Bioethics: Implications for Medical Practice and Deontologic and Legal Standards in Brazil

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This article analyzes moral issues involving professional ethics in Brazil and provides appropriate up-to-date references to Brazil's Code of Deontology (1984), Code of Medical Ethics (1988), and civil and criminal codes. The analysis considers various trends that have emerged as a result of recent medical advances and discusses bioethical issues in the areas of family planning, abortion, medical research on human subjects, euthanasia, transplants, and professional confidentiality.

Human existence, whether individual or collective, is fundamental to all the goods and interests protected by law. And since life, bodily integrity, honor, and liberty are the supreme values of human existence, their protection is a paramount duty of the State as it seeks to fulfill its role of preserving and perpetuating the species, maintaining ecological equilibrium, and promoting the peace essential to community survival.

Recent scientific discoveries and the extraordinary pace of scientific and technological development have unquestionably increased man's power to control nature. But they have also increased the threat to life. Furthermore, the advances of science and technology have not generally been accompanied by comparable advances in morality and ethics—creating an imbalance that has tended to expose contradictions inherent in human nature.

In other words, major scientific discoveries, if well used, can greatly benefit humanity, but if misused they can also endanger or destroy it. Therefore, it is incumbent upon the moral conscience of

the scientific community to know how to apply such discoveries properly. And it is incumbent upon those who establish the rules by which society lives, the technical and legal authorities, to establish rights and obligations that will lead to such proper applications being made.

Within this context, it seems clear that technical skills, which express the dialogue between the hands and the brain, must be subordinated to reason and knowledge, which regulate action so that human nature is not demeaned but is free to develop its full scope and potential. Here medical professionals pursuing their mission of preventing, treating, curing, and minimizing human suffering are at the center of attention. Their activity, involving as it does the supreme individual values of life and health (activity which because of its importance is subject to government supervision), creates very close links between medicine and the law.

At present, a wide range of medical actions posing possible risks to the rights of individuals, social welfare, and basic human conditions are attracting considerable public attention. Such actions cut across a wide range of fields—including genetics (e.g., genetic alteration of micro-

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organisms, potential modification of human genes, release of genetically altered organisms into the environment); human reproduction (e.g., abortion, artificial insemination, birth control, sterilization); medical research (e.g., experiments involving human subjects); surgery (e.g., plastic surgery, transplant of organs and tissues, transplant of bodily parts, use of artificial organs); and termination of life (e.g., euthanasia)—as well as involving more general issues such as medical confidentiality, the deliberate withholding of medical assistance, and medical responsibility.

Much of the concern to date, and most of the studies being performed as a result, are directed at ensuring the observance of well-defined ethical standards derived from general principles that are compatible with humanity's best interests. Among other things, it seems clear that medical studies and research should be carried out using appropriate scientific and technical controls that simultaneously safeguard the interests of the researchers, their subjects, and society at large.

More broadly, free exercise of the medical profession involves actions that cannot pertain exclusively to the private sphere, given that from a legal standpoint health and life constitute undeniable and inalienable goods. Hence, it is imperative that medical activities be regulated and that standards enshrined in the so-called deontologic codes be improved. At present these standards appear increasingly unrealistic and subject to influence in many cases by marketing technologies that contribute to undesirable distortions of medical practice.

Morality, strictly speaking, is not the same as ethics. Morality involves acquired behavior or the manner in which behavior is learned by people in a social setting; while ethics, far from being a series of rules and instructions, is the the-

ory or science dealing with moral behavior of people in society. Bioethics, then, is the application of this same theory to the practice of acts that affect human life—that may help to improve, preserve, or save it, or that can mutilate or destroy it.

In reality, the great prominence of medical ethics in recent years has not been due to any resurgence of moral, philosophic, or theologic principles; nor has it resulted from growing feelings of responsibility arising within a medical profession upset by the present health care situation. Rather, medical ethics has received greater attention because of mounting public concern about the behavior of health professionals, especially physicians. Indeed, it is often felt that codes of ethics are merely being used as a screen to conceal malpractice and medical errors; and some people have come to believe that these codes are nothing more than a device for maintaining physicians as a class immune from judgment by the community.

Every profession is anxious to appear efficient. In the health sector, professionals such as doctors once had to compete with healers, mothers, and others before they were able to establish their professional monopoly, exercise professional autonomy, and exclude interference from outside individuals and judgments. From this point of view, it is not so difficult to conclude that a physician should only be judged by other physicians, that any admission of medical error would amount to belittling the profession, and that medical errors are, above all, a product of the surrounding system.

As medicine and medical technology became increasingly specialized, however, physicians could no longer work alone. Instead, they began to work with and for the institutions that made their activities possible. And as medical care became increasingly expensive, the gov-

ernment and private companies came increasingly to bear the costs of treatment. Consequently, in large measure the physician came to trade his position as an autonomous professional for that of an agent of these institutions; and his work came to reflect distortions created by large corporations active in the sector.

Meanwhile, technologic advances in medicine, juxtaposed with our present disease-producing social crisis, have put the physician in a difficult position. On the one hand, many claims of technologic efficiency have the aim of promoting greater use of particular equipment, machines, and drugs to cure diseases. And on the other, there is a fundamental conflict—for it seems clear that no matter how sophisticated it becomes, medical assistance is not going to solve the basic social problems of the population.

The growing number of tests and other exploratory techniques now available, such as those used to assess people's genes in order to foretell future diseases in a person or that person's descendants, are currently causing concern. If it were possible to do something about such diseases or prevent them from harming the next generation, then these tests should be carried out. However, since some of these tests detect illnesses for which there is as yet no treatment, it is arguable whether the knowledge thus acquired is really useful or of anything but limited immediate value. Nevertheless, many scientists believe that an awareness of future health status (even if that status is bad) may help people to plan their lives better. In some cases, therefore, the benefits outweigh the costs, and the resulting good exceeds the risk. In addition, one must consider whether or not the person to be tested desires the test—because in some cases, such as when an individual is suspected of harboring the AIDS virus, the person may not wish to undergo the test.

Whatever the benefits, however, recent studies show that such tests are tending to become more common; and ongoing research on such problems as Alzheimer's disease, depression, manic disorders, schizophrenia, Huntington's disease (a rare and fatal brain disease), juvenile diabetes, and others is raising new and difficult questions in the fields of medicine and law, in matters of human intimacy and professional confidentiality, and in many detailed sorts of decision-making such as whether it is wise to tell somebody he is suffering from a serious disease, especially if it is incurable.

Deontology (from the Greek *deon*, duty), defined as study of the individual's moral obligations within the community, relates to moral action. Such action is understood to be action that is performed in the presence or with the participation of another person, that involves a choice of alternatives, and that depends upon the influence of feelings, the censorship of conscience, the means employed, the ends sought, and the formulation of judgments. In sum, such actions may be envisaged as depending upon a structure of interconnected motives, will, goals, and results.

In addition to being encompassed within this structure, moral action is also subject to ethical concerns of the individual himself (conscience), and also of class, community, nation, and history. As this suggests, morality in general, as well as morality relating to the health professions, is not the same at all times and places. That is, it changes as values change and as progress is achieved in integrating conscience and liberty into moral action.

ETHICAL CONTROL: DISCIPLINE OF THE HEALTH PROFESSIONS

In Brazil, the Federal Medical Council and regional medical councils established

by Decree Law No. 7.955 of 13 December 1945 are the bodies responsible for supervising medical ethics. They judge (and when necessary discipline) members of the medical profession, it being their duty to promote fully ethical conduct by the medical profession and to safeguard the prestige and good standing of the profession and its practitioners—in accordance with Law No. 3.268 of 30 September 1957 and the regulations authorized in Decree No. 44.045 of 19 July 1958. Other health-related professions are supervised in this manner by other federal and regional councils. Over the past three decades, three codes of medical ethics have been approved in Brazil. These are the Code of Medical Ethics approved on 11 January 1965, the Brazilian Code of Medical Deontology approved on 13 April 1984, and the current Code of Medical Ethics, approved on 26 January 1988. The latter, containing 145 articles, concerns itself with establishing fundamental principles regarding rights, responsibilities, prohibitions, and other matters affecting the medical profession—including relationships between the physician and the patient, the patient's family, and other physicians; professional confidentiality; remuneration; medical research; publicity; issuance of certificates and bulletins; and general standards. Again, other codes of ethics have been issued in recent decades for the other health-related professions—such as pharmacology, nursing, dentistry, etc.

FAMILY PLANNING

In no circumstances whatever is it right for man to act contrary to the dictates of his conscience. It is quite possible that one may need to study a question further, or that one's conscience may be wrong, but it will never be right to act against one's conscience. Whatever one

may do in an attempt to determine what the right action is, when the moment for that action comes there is always the matter of personal responsibility. Nobody, not even the Church, can exempt anybody from having to follow their conscience and accept responsibility.

Regarding human reproduction, the State cannot impose mandatory birth control. Without an inalienable right to marriage and procreation, human dignity cannot exist (*Populorum Progressio*, No. 37). However, public authorities, acting within the limits of their powers, can intervene by promoting relevant education and taking other appropriate measures, so long as they observe the requirements of the moral law and respect the liberty of spouses. The State should also see that those who need it receive appropriate information and education regarding the methods that Christian morality permits for purposes of responsible birth control. Poverty cannot be a reason for discrimination in this matter.

Because the concept of human dignity presupposes an inalienable right to procreation, parents have the right and the duty to decide how many children they will have—in other words, to exercise responsible parenthood and to use family planning. Indeed, responsible parenthood of this sort is necessary, not only for social welfare, but also for purposes of providing a balance between population growth and human and economic resources.

All too often, accelerating population growth complicates the problem of development; it is for this reason that studies and research in the area of human reproduction are urgently required. However, population policy is only a part of general development policy, not an alternative to it. And final decisions involving practical action with regard to responsible parenthood depend on the individual conscience of each person; nobody should be

forced or induced to act against his own wishes.

It should also be noted that family planning does not necessarily mean "limiting the number of children." A well-planned family may contain 10 or more children, provided that they live in hygienic and healthy conditions and have the necessary social and economic support to guarantee their education and livelihood.

It may be asserted that law, religion, sociology, and politics are all in agreement with the important concept of responsible parenthood. The Encyclical *Humanae Vitae*, broader and more enlightened than *Casti Conubii*, defends birth control as legitimate and in a number of places speaks of "responsible parenthood." Hence, disagreement among the various schools of thought is not about family planning itself, but rather about the methods used to provide reasonable spacing between pregnancies.

There is nothing illegal about family planning as such in any branch of Brazilian law. It is no crime to provide guidance to spouses regarding birth control practices, or for them to act on such guidance so long as the couple's liberty is respected. However, surgical sterilization, when not performed at medical direction, involves the destruction of the reproductive function, and therefore does grave bodily harm. There can be no justification for such action, even when it is based on the written consent of the wife or husband, since life and health are undeniable and inalienable goods.

The laws governing the organization of health systems in the states of Acre, Alagoas, Amazonas, Bahia, Ceará, Espírito Santo, Goiás, Pará, Paraíba, Piauí, Rio Grande do Norte, Rondônia, and Sergipe already contain the following stipulations:

- Measures to protect the health of

mothers and children shall always have as their guiding principle the strengthening of the family, and any actions in this area must be grounded upon ethical and humanistic foundations.

- No steps shall be taken that may affect the offspring except on the basis of a medical recommendation to that effect designed to protect the mother's health and based on the freely expressed assent of the parties.

Article 226, Paragraph 7 of the 1988 Constitution of the Federal Republic of Brazil states the following: "Based on the principles of human dignity and responsible parenthood, family planning is the free decision of the couple, it being the State's function to provide educational and scientific resources to enable this right to be exercised, any form of coercion by public or private institutions being prohibited."

ABORTION

According to the Brazilian Civil Code, the rights of the fetus are protected from the time of conception (Article 4). In addition, the Criminal Code (Articles 124 to 127) makes it a crime to cause an abortion, except in two situations described in Article 128, as follows: "Article 128—An abortion performed by a doctor shall not be punished when: (I) there is no other way of saving the mother's life; (II) the pregnancy results from rape and the abortion is preceded by the consent of the mother or, when she is incapable, her legal representative."

Hence, legal abortion performed by a doctor, known as "necessary abortion," is performed to save the life of the mother or to avoid the birth of an offspring resulting from rape. In this manner the Criminal Code recognizes two sit-

uations in which abortion is not a crime, one depending on a medical opinion and the other on emotional considerations. However, the wording of Article 128 is excessively simplistic and leaves scope for criminal abortion. Indeed, one can argue that the existing provisions should be amended to make it impossible for certain unscrupulous professionals to take advantage of them and practice illegal abortions on the grounds that heroic steps are being taken to save a life.

The draft Criminal Code (Special Section), published in October 1987 by the Ministry of Justice to encourage comment, provides for the possibility of so-called "eugenic abortion" when there are good grounds, certified by two doctors, for believing that the fetus shows signs of serious and irreversible physical or mental anomalies, provided that prior consent has been given by the pregnant woman or, when she is incapable, by her legal representative and, if she is married, by her spouse.

However, the legality of a necessary abortion does not depend on the consent of the pregnant woman or of third parties, since in the right circumstances it is fully protected by the law and by the precepts governing medical science. Nevertheless, current medical progress is steadily reducing the criteria justifying abortion as a means of preventing death of the mother.

Some people feel that the type of "necessary" abortion performed in connection with rape—also known as "sentimental" or "moral" abortion—can no longer be justified, because it gives the physician the right to take a life. And in such cases there are clearly no circumstances that could be deemed to make abortion a medical necessity. It is also said that it is extremely difficult to prove rape, and that for a doctor to terminate a pregnancy on these grounds is a simple way of obtaining an immediate abortion.

From the standpoint of the criminal law, there is no need for a conviction of rape to be obtained in order for the abortion to be permitted—it is enough for there to be convincing proof of the existence of a sexual offense. One reason is that charges are not brought in rape cases unless a complaint is filed, with two exceptions. That is, proceedings are brought via public action (Article 225 of the Criminal Code) if the victim or her parents cannot meet the costs of filing suit without using funds essential for their support, or if the crime involves abuse of a father's legal authority or abuse of a stepfather's, teacher's, or guardian's position. (In the former case, action by public authorities depends on representations made by the victim or her legal representative.)

Nelson Hungria, in his *Comments on the Criminal Code* (vol. 5, p. 313, 1958), says "If criminal proceedings are in progress against the accused rapist, it would be advisable for the judge and representative of the public prosecutor to be consulted, since their approval will not be refused if there is sufficient evidence for the preventive detention of the accused." And again: "In practice, to avoid abuses, the doctor should only act on the basis of conclusive evidence of the alleged rape, unless the offense is common knowledge or the rapist has already been convicted. In the meantime, if the doctor's knowledge of certain circumstances is such as to justify a reasonable belief regarding the possibility of rape, no blame will be attached to him should the allegations subsequently prove to be untrue. In such circumstances it is only the pregnant woman who will be criminally liable."

Regarding ethical codes, Article 54 of the Medical Ethics Code published in 1965 reads as follows: "The doctor must not perform an abortion except when there is no other way of saving the

mother's life or when the pregnancy is the result of rape, and then always only after receiving the express consent of the mother or her legal representative. Par. (1): In either of these situations provided for in the law, the doctor may only act after conferring with at least two other colleagues. Par. (2): A record in triplicate shall be kept of this conference, one copy being sent to the Regional Medical Council and another to the clinical director of the establishment in which the operation is to be performed, with the third remaining in possession of the doctor who is performing the operation."

The Brazilian Code of Medical Deontology, approved by Resolution CFM No. 1.154/84 of 13 April 1984, merely prohibits doctors "from failing to comply with the specific legislation regarding cases of abortion" (Article 12) and from "performing, except in cases of urgency or emergency, any medical procedure without the prior consent of the patient or her legal guardian" (Article 24). The current Code of Medical Ethics, approved in 1988, omits any reference to abortion.

A number of increasingly insistent efforts have been made, using false arguments, to obtain support for an unacceptable legal protection of abortions, the most prominent claim being that clandestine abortions must be countered by legalizing or decriminalizing the practice. However, it can be argued to the contrary, on the basis of statistical evidence, that permissive laws do not eliminate clandestine operations, but instead produce a staggering increase in the ratio of abortions to live births.

EXPERIMENTS AND MEDICAL RESEARCH

The Code of Medical Ethics currently in force in Brazil prohibits doctors from participating in any kind of experiment

on human beings for military, political, racial, or eugenic purposes. It also bars experimental use of any treatment not yet approved for use in Brazil without proper authorization from the competent bodies and consent of the patient or person responsible. Such consent must be "informed" consent, in that the patient or person responsible must be duly informed of the relevant circumstances and possible consequences of the treatment before his or her consent is obtained.

The same code also prohibits any attempt by a physician to seek personal advantage or commercial gain from those financing medical research in which the doctor is participating. It requires that all medical research on human beings be approved and monitored by a committee that is not dependent upon or subordinate to the researcher in any way. It bars performing or participating in medical research that puts the patient at risk by suspending or stopping approved forms of treatment. And it prohibits any experiments involving new clinical or surgical treatments upon patients with incurable or terminal disease, unless there is reasonable hope of its being beneficial without imposing additional suffering.

More recently, in Resolution No. 1 of 13 June 1988, the National Health Council of the Ministry of Health issued regulations governing research in the health field. Specific matters covered include ethical aspects of research on human beings; utilization of new forms of treatment, diagnosis, therapy, and rehabilitation; use of under-age subjects, individuals not in a position to give informed consent, women of childbearing age, and pregnant women; tests performed during pregnancy, childbirth, the puerperium, and lactation; research on individuals where something less than full and spontaneous consent may be assumed; research involving corpses, parts of the human body, organs, tissues, and

organ and tissue by-products; pharmacologic research; research employing pathogenic microorganisms or biologic material that may contain them; research that entails the engineering and handling of recombinant nucleic acids; and research employing radioactive isotopes as well as devices and generators producing ionizing electromagnetic radiation. This National Health Council resolution deals with the activities of ethics and biological safety committees, as well as with research conducted by health institutions generally, and contains rules governing such work.

In this way, the resolution has filled a gap in Brazil by addressing the issue of medical research on human subjects. This issue has been arousing social controversy—because it may entail abuses, may represent a threat to man's physical integrity or health, and may involve illegal acts even after voluntary consent has been obtained. Failure to observe these regulations may constitute violations of an ethical-disciplinary or criminal nature (crime of direct or immediate danger, Article 132 of the Criminal Code), or of a health-related nature, contravening Law No. 6.437/77.

EUTHANASIA

The current debate over euthanasia is both necessary and inevitable. Even in Brazil, medicine has already reached that paradoxical point where it is possible to prolong life but not to bring an individual back from a vegetative state.

Euthanasia, a word whose meaning signifies "good death," "induced death," or, more simply, the "right to kill," finds no support in Brazilian law or in the postulates of medical ethics. Indeed, euthanasia offends the national conscience, which cannot accept as lawful the right to die or the right to kill, since they contravene morality, customs, and public law.

On this point the current (1988) Code of Medical Ethics stipulates that a physician must use all the diagnostic and treatment resources at his disposal on behalf of the patient; it also prohibits him from employing, under any circumstances, means intended to shorten the patient's life, even at the request of the patient or whoever is legally responsible for him (Articles 57 and 66).

Furthermore, the Brazilian Penal Code punishes homicide, with which euthanasia can be equated because it involves the crime of "killing somebody." It is not suicide, although paradoxically it may have the characteristics of the crime referred to in Article 122 of the Penal Code, namely "assistance, inducement, or instigation to commit suicide." In addition, euthanasia is a civil offense because it causes harm to somebody (Civil Code, Articles 159 and 1.549).

In the light of all this, there is no possibility of legitimizing euthanasia or of giving a doctor or anyone else the right to perform it, even if he were invested with excellent motives—assuming that this were possible. Moreover, although attempts might be made to show that a doctor, in refraining from treating an incurable patient, was not committing euthanasia, the mere failure to provide treatment could lead to ethical and disciplinary action as well as civil and criminal penalties.

The purpose of the law is to promote the common good and ensure that each individual may fully enjoy his rights. These rights are supposed to include physical and moral safety, as well as effective protection against aggression and violence. Since life is our most prized possession, the law only performs its protective mission when it prescribes serious penalties for those depriving others of their lives. Consequently, the decriminalization of euthanasia, so as to permit advancing the deliberately "anticipated"

death of a sick person on grounds of preventing suffering, even with the victim's consent (or that of immediate family members), offends greatly against both Christian morality and the law.

TRANSPLANTS

Transplants of human body parts, organs, and tissues have raised a variety of technical, scientific, legal, moral, and theologic questions that must be dealt with by physicians, transplant donors, and transplant recipients. The subject is rife with all sorts of implications relating to life and death: the abnegation of the donor, the hopes of the recipient, the notion that part of a corpse may save a life, and so on. The most controversial issues relate to authorization for the transplant. Among other things, should the express authorization of a living donor be required or not?

In Brazil these issues are governed by Law No. 5.479 of 10 August 1968, which many people believe leaves much to be desired. The deficiencies cited relate mainly to the criteria used to determine death, the form in which donations are made available, authorization for transplants in cases of suicide and accidents, and the summary manner in which it deals with the range of operations involved. At present a number of bills are being discussed in the National Congress, but so far none has been approved.

In any event, it would seem that a sound code on transplants must establish five prerequisites—real necessity; professional confidentiality; exclusion of sensationalistic purpose; absolute confidence that the operation is not an experiment on human beings but only and indisputably a therapeutic action on behalf of the patient; and finally, reliable determination of the death of a potential donor,

which is absolutely essential in such circumstances.

MEDICAL SECRECY— PROFESSIONAL CONFIDENTIALITY

Medical secrecy is strictly regulated by criminal law, the penal code, civil law, and medical deontology. However, there are permitted exceptions and a wide range of complications causing uncertainties that, in many cases, the law does not admit.

One reason for such complications is this: Clearly, maintaining confidentiality in the exercise of a profession is designed above all to protect and defend moral and material goods. Hence, the State should see to it that individuals find solutions while preserving this secrecy. In some cases, however, community interest needs to take precedence over individual interests, though it is not always easy to determine which those cases are.

According to the Criminal Code (Article 154), anyone who reveals facts of which he is aware as a result of his function, office, or profession without proper cause, and thereby actually or potentially harms another person, is liable to a prison term of three months to two years or a fine of 1,000 to 10,000 cruzados. On the other hand, a doctor who fails to inform the public authorities of a disease whose notification is compulsory is liable to a prison term of six months to two years or a fine of 500 to 3,000 cruzados (Article 269).

The criminal law also precludes "failure to communicate to the competent authorities. . .[a] public offense, of which he was aware in the exercise of medicine or another health-related profession, provided that the offense does not result from the act of representation and the communication does not expose the cli-

ent to criminal proceedings. Penalty: fine of from 300 to 3,000 cruzados."

Meanwhile, the Civil Code (Article 144) states that "Nobody may be obliged to state facts regarding which, as a result of his status or profession, he should keep secret."

Chapter IX of the current Code of Medical Ethics approved in January 1988 and published in the Official Gazette on 26 January of that year prohibits the following physician actions:

- "Article 102—To reveal information he knows by virtue of exercising his profession—except for just cause, legal obligation, or express permission of the patient.

Sole paragraph: This prohibition remains in effect: (a) Even when the information is public knowledge or the patient has died. (b) When he gives evidence as a witness. In this situation, the doctor shall appear before the authorities and state why he cannot testify.

- "Article 103—To reveal professional secrets pertaining to a patient who is a minor, including to his/her parents or legal guardians, provided that the minor is capable of assessing the problem and arriving at a solution to it on his/her own, except when not revealing the information may harm the patient.
- "Article 104—To refer to identifiable clinical cases; to exhibit patients or their pictures in professional announcements or in the dissemination of medical matters on radio or television programs, in movies, or in articles, interviews, or reports in journals, magazines, or other publications.
- "Article 105—To reveal confidential information obtained during medical examinations of workers, even when

requested to do so by managers of enterprises or institutions, unless keeping silent jeopardizes the health of the employees or the community.

- "Article 106—To provide insurance companies with any information regarding the circumstances of death of any patient except that contained in the death certificate itself, without the express authority of the legal representative or heir.
- "Article 107—To fail to instruct his assistants or ensure that they observe professional secrecy as stipulated by law.
- "Article 108—To facilitate the handling and inspection of dossiers, papers, and other notes of medical observations that are protected by professional secrecy by persons not similarly obligated.
- "Article 109—To fail to preserve medical secrecy in collecting fees by legal or other means."

In legal terms, if one is to determine that professional confidentiality has been violated, it is necessary to show that (a) a secret existed that was known to the violator by virtue of his function, office, or profession; (b) revelation of the secret could potentially harm someone; (c) there was no just cause for violating confidentiality; or (d) there was fraudulent intent.

From the standpoint of the criminal law, the willful factor in the crime occurs when the agent has a free and knowing desire to cause harm to another person (a directly criminal act) or when he risks causing harm even if not intending a harmful result (a potentially harmful act). In the latter case there is a basis not for legal punishment but for blame (for negligence, malpractice, or imprudence).

The notion that a just cause can be sufficient to overrule the commitment to

confidentiality in keeping medical secrets depends, essentially, upon moral or social benefit that does or does not support such action, assuming considerable motivation capable of justifying the violation. In this context, a "secret" is understood to mean something known by one person or a limited number of people with an interest in keeping the knowledge hidden, because its revelation could cause harm. Similarly, "medical confidentiality" means the secrecy that the medical professional is obliged to maintain regarding certain facts he knows as a result of exercising his profession, with the aforementioned exceptions in special cases.

The principal reason for observing medical confidentiality is to gain the confidence of the patient, whose information is essential to ensure sound diagnosis and efficient treatment. And although justification on these grounds may seem less than absolute, there are those who maintain that a doctor's duty is absolute and leaves him no discretion.

Other more flexible positions derive from the modern notion that since life and health are goods protected by the State and medicine is rapidly becoming a true public service, the public interest should prevail over private interests. Therefore, in certain cases there is justification for breaking both traditional medical confidentiality and the portion of the Hippocratic Oath that says "What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account must be spread abroad, I will keep to myself."

To demonstrate changing attitudes toward stringent medical confidentiality it has become customary to cite current practices such as the televising of very complex operations or the publicizing of medical announcements through the mass media. Consideration must also be

given to the fact that society has pertinent interests; what is at stake is the right of the community to mitigate the rigor of medical secrecy in its absolute form. Medical professionals have duties and obligations that are more important than their individual commitments, since their science and art are daily assuming an increasingly public character. To remain silent, for example, when an innocent person is condemned appears absurd, an unjust act of complicity.

Nonetheless, it should be noted that breaking the confidentiality that should govern the practice of medicine occurs only exceptionally, in very special situations, or when the law, recognizing a higher right to be protected, allows confidentiality to be broken.

Some authors like to enumerate situations in which laws made in the collective interest require that medical secrecy be broken, such as, for example: (a) in completing a declaration of birth or a death certificate; (b) to prevent a marriage, in the case of certain diseases that may endanger the health of one of the spouses or their offspring; (c) in declarations regarding communicable diseases; (d) when an illegal (criminal) act is involved; (e) in cases of child abuse, where injuries or diseases are involved that require care by the family and involve third parties; (f) in medico-legal examinations; (g) in dealing with criminal abortions; (h) in legal proceedings to collect medical fees; and (i) in providing information for hospital records.

Medical secrecy must be preserved principally to protect the interests of the patient, not just the reputation of medical science. On the other hand, it cannot be a crime to break medical confidentiality when there is a need to protect a more relevant contrary interest.

The legal basis for medical secrecy is the result not of a private interest contract but a public order stipulation. To re-

main silent against the interests of justice, for example, would be to give secrecy the character of complicity. As this shows, the idea that professional secrecy can never be broken cannot be reconciled with modern social realities or with public order—and so, in the face of pertinent social concerns, the precept becomes relative. Accordingly, modern legal thinking is not so strict as it used to be when such rigor is prejudicial to discovering the truth, or when it runs counter to what preserves the moral and social order and collective social welfare.

In practice, various situations arise that raise the issue of medical confidentiality. Along with the obligation to cure the sick, a physician is also obliged to protect other people against certain diseases. For example, a physician may learn that a patient with a contagious disease is reluctant to stop going to work—in which case he may be obliged to inform the competent authorities of the situation. Or, paradoxically, it may be necessary to break confidentiality to protect the patient's health or life. For example, a psychiatrist may determine that it is reasonably likely that a mental patient will try to kill himself. In such a case it is his duty to communicate this fact to the patient's family.

In general, however, the most complex questions tend to involve certain imperatives of law and justice. Within this area there are some cases in which the doctor must only respond to what he has been asked, and others that can only be resolved by the submission of his clinical report, which thereby releases him from any future responsibility.

Regarding epidemiologic surveillance, Article 10 of Law No. 6.259 (30 October 1975) provides that compulsory notification of diseases involves confidentiality binding upon the health authorities receiving the information. According to the sole paragraph of this Article, "Patients suffering from diseases whose notifica-

tion is compulsory may only be identified, outside medical and health circles, in exceptional circumstances involving major risks to the community, at the discretion of the health authorities and with the prior knowledge of the patient or those responsible for him." Failure to observe this rule is a violation of the health regulations and makes the agent subject to the penalties provided for in Law No. 6.437 of 1977 as part of an administrative process providing ample safeguards to defend the identified patient. Here, then, is an instance in which the legislators decided to defend medical confidentiality while making its observance less than absolute in cases involving serious potential risks to the community.

In closing this overview of confidentiality issues, it seems appropriate to note the ethical questions raised by the spread of AIDS in Brazil. In particular, this has presented physicians with a conflict between protecting their patient's welfare by maintaining professional confidentiality and preventing the infection and death of other people by breaking it. This problem has led Brazil's Federal Medical Council to issue a recent statement asserting that "the desire of the patient who does not wish his condition to be revealed to family members must be respected. The ban on this secrecy being broken remains in effect after the patient's death, but special situations exist that can give rise to exceptions."

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Conference on International Travel Medicine

The Second Conference on International Travel Medicine will be held in Atlanta, Georgia (U.S.A.), from 9 to 12 May 1991. The conference is being cosponsored by the World Health Organization, the World Tourism Organization, the U.S. Centers for Disease Control, the Emory University School of Medicine (U.S.A.), and the London School of Hygiene and Tropical Medicine (U.K.). Topics to be discussed include the following: overview of health risks for travelers and individual preventive measures; malaria; travelers' diarrhea, respiratory diseases, and other infections; AIDS and other sexually transmitted diseases; vaccine-preventable diseases; vaccines, immunoglobulins, and chemoprophylaxis; noninfectious diseases, including jet lag and motion sickness; accidents and injuries; environmental health hazards; health promotion for travelers; and medical care abroad.

Scientific inquiries should be addressed to: Dr. Hans O. Lobel, Mailstop F12, Centers for Disease Control, Atlanta, GA 30333, U.S.A. (fax no. 404-488-4427). Program and registration information are available from: Second Conference on International Travel Medicine, 104 Woodruff Health Sciences Administration Building, 1440 Clifton Road NE, Atlanta, GA 30322, U.S.A.

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