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Confidentiality in occupational medicine: protecting information

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Abstract

Confidentiality is a central element of the physician-patient relationship and is associated with good quality of care. However, it may be broken in accordance with the ethical and legal standards established in the country. This study aims to show the main aspects of confidentiality in occupational medicine. For this, a narrative review of the literature on the subject was carried out, using free access databases and based on the codes of medical ethics. The occupational physician's performance involves the worker, other non-medical professionals and the employer, a situation that may trigger conflicts, requiring physicians to know their obligations and ethical-legal limits. The protection of confidentiality respects human rights, but dilemmas may arise, not only to obey ethical precepts, but to follow legal norms. This study seeks to show the main and updated ethical and legal aspects regarding occupational health.

Keywords: Occupational medicine. Confidentiality. Professional autonomy.

Resumo

Confidencialidade em medicina ocupacional: protegendo informações

A confidencialidade é elemento central da relação médico-paciente e está associada à boa qualidade do atendimento. Contudo, pode ser rompida em conformidade com as normas éticas e legais estabelecidas no país. Este estudo objetiva mostrar os principais aspectos da confidencialidade em medicina ocupacional. Para isso, realizou-se revisão narrativa de literatura sobre o tema, utilizando bases de dados de livre acesso e embasando-se nos códigos de ética médica. A atuação do médico do trabalho envolve o trabalhador, outros profissionais não médicos e o empregador, situação capaz de desencadear conflitos, requerendo que o médico conheça suas obrigações e limites ético-legais. A proteção da confidencialidade respeita os direitos humanos, mas dilemas podem surgir, não bastando obedecer aos ditames éticos, mas sendo necessário essencialmente seguir as normas legais. Este estudo busca mostrar os principais aspectos éticos e legais atualizados referentes à saúde ocupacional.

Palavras-chave: Medicina do trabalho. Confidencialidade. Autonomia profissional.

Resumen

Confidencialidad en medicina del trabajo: protección de información

La confidencialidad es clave en la relación médico-paciente y está asociada a buena calidad de la atención. Sin embargo, está sujeta a una quiebra de conformidad a lo establecido en las normas éticas y legales en el país. Este estudio pretende mostrar los principales aspectos de confidencialidad en la medicina del trabajo. Para ello, se realizó una revisión narrativa de la literatura en las bases de datos de acceso abierto basándose en códigos de ética médica. El actuar del médico del trabajo involucra al trabajador, a profesionales no médicos y al empleador, lo que puede desencadenar conflictos requiriendo que el médico conozca sus obligaciones y límites ético-legales. La protección de la confidencialidad respeta los derechos humanos, pero pueden surgir dilemas y no solo bastará atenerse a los dictámenes éticos, sino seguir fundamentalmente las normas legales. Los resultados mostraron los principales aspectos éticos y legales actualizados relacionados con la salud laboral.

Palabras clave: Medicina del trabajo. Confidencialidad. Autonomía profesional.

Research

The authors declare no conflict of interest.

Confidentiality is the cornerstone of medical care, structuring the physician-patient relationship and expressing mutual trust between the parties. This principle supersedes moral duty, becoming a legal obligation [1]. To be accepted, it is not enough to ensure that medical information is not disclosed: professionals must ensure that data related to the patient's health are kept safe and, when disclosure is mandatory, that they are disclosed within the strictest ethical-legal rule, as recommended by the International Code of Ethics for Occupational Health Professionals [2,3] and the Code of Medical Ethics (CEM) of the Federal Council of Medicine (CFM) [4].

Occupational physicians must obtain information absolutely necessary for their performance, always in accordance with national legislation, respecting confidentiality and the general principles of occupational health and safety [2]. Employees, in turn, have the right to privacy and the protection of information related to their health. However, this task is not always simple, as medical information may be required in court or in situations of collective interest. One should also consider that other professionals are also involved in occupational medicine, including those who are not in the medical area, as well as the employer [3].

The sharing of employee health information with the team of non-medical specialists is essential for the management of workplace safety, and these professionals are required to maintain professional secrecy. This, therefore, does not constitute a violation of the worker's right to confidentiality, in accordance with what is described in article 85 of CEM [4], which specifies that persons not obliged to secrecy are prohibited from accessing the records. Moreover, worker health data can also be requested by labor and judicial authorities, in addition to social security organizations, making medical work more confusing [5]. Thus, there are several dilemmas faced by the occupational physician, which, according to Emanuel [6], were quite neglected in bioethical terms.

Thus, this study aims to address the main aspects related to the confidentiality of information in occupational medicine, with the purpose of assisting the specialist in his/her daily work, given the multiple demands of the various legal forums and those of a social security nature.

Method

This is a narrative review, with a descriptive-discursive method, carried out at the ABC School of Medicine and at the University of São Paulo School of Medicine. To support this research, scientific studies available in the main open access databases were collected. The applied descriptors were *occupational health physicians*; *médicos laborales*; *médico do trabalho*; *confidentiality*; *confidencialidad*; and *confidencialidade*. Articles obtained in full and published in Portuguese, English or Spanish were included. Also covered in this study were CFM Resolution 2,217/2018, which approves the CEM, the Medical Ethics Manual of the World Medical Association [7] and the International Code of Ethics for Occupational Health Professionals [2].

Discussion and results

Brief history of occupational medicine

Work has been described, since antiquity, as a factor of illness or associated with it. Papyri dating from 1600 BC mention injuries or death of workers during the construction of the Egyptian pyramids. Hippocrates, the father of medicine, described, in 460 BC, that the origin of some diseases was related to the patient's labor occupation [8]. In the second century AD, Galen acted as a doctor for gladiators, and Bronze Age archers wore what we would now call personal protective equipment on their fingers and wrists to prevent injury [9].

According to Franco and Franco [10], Bernardino Ramazzini, in his work published in 1700, *De morbis artificum diatriba*, or *The Sicknesses of the Workers*, was perhaps the first author to systematize the damage caused to artisans due to certain practices of their craft. The author highlighted the association between the illness of workers and harmful movements or postures, focusing on repetitive movements and load lifting. In the preface to the book, as Franco [11] quotes, Ramazzini also explained the ethical and social reasons why the physician and society should be concerned with the health of the worker, based on two virtues: compassion and gratitude [11].

However, the specialty of occupational medicine arose only from the Industrial Revolution

Research

in England, when workers were subjected to inhumane conditions, with high rates of morbidity and mortality [12]. It was under the guidance of doctor Robert Baker that the businessman Robert Dernham, owner of a textile factory, hired for the first time, in 1830, a physician as responsible for the care of workers [12].

The International Labor Organization (ILO), in turn, was created in 1919, aiming to meet, in response to the growing international concern about the subject, the health needs of workers, improving their organization in groups and giving them some power to pressure the owners of the means of production [13]. Consequently, the need arose to establish a list of occupational diseases, initiated in 1910 by Theodor Sommerfeld and Richard Fischer, whose purpose was to establish its legal security framework. The ILO only published its first list in 1925. It only contained three diseases (saturnism, hydrargyrism, and carbuncles) [13], which, although timid, brought major changes and was progressively expanded by the inclusion of new conditions. In 1953, at the request of international entities, the specific training of physicians specialized in worker care was promoted with the ILO Recommendation 97 on the protection of workers' health [14].

Decree 3,724/1919 defined occupational accidents and established the rules for compensating workers as a result of occupational accidents:

Art. 1 The following are considered to be work accidents for the purposes of this law: Ia) that produced by a sudden, violent, external, and involuntary cause in the exercise of work and certain bodily injuries or disturbances which constitute the sole cause of death or total, partial, permanent or temporary loss of capacity for work; Ib) the illness contracted exclusively by the exercise of work, when of a causal nature by itself, and provided that it determines the death of the worker, or total, partial, permanent or temporary loss of capacity for work [15].

In 1943, Decree-Law 5,452 [16] approved the Consolidation of Labor Laws (CLT), which brought advances in individual and collective labor relations. Currently, Law 8,213/1991 [17] provides for social security benefit plans and other measures to the insured in the General Social Security System.

Considered an area of preventive medicine, occupational medicine requires health professionals to have knowledge of general and emergency medical areas, environmental and ergonomic notions, and the ability to assess the employee's fitness for work [18]. Thus, occupational medicine surpasses simple medical knowledge, admitting several interfaces.

The management of health risks has become outdated and new burdens have been incorporated into occupational medicine, such as health surveillance, employees' work capacity analysis, employees' rehabilitation, risk assessment, admission examination, chronic disease monitoring, illnesses prevention, and health promotion in the workplace. Inevitably, broad ethical discussions emerged in the field of confidentiality of the worker's medical information [19,20].

Medical confidentiality: a timeline

Medical confidentiality is the protection of personal health information given in confidence by the patient to the physician, which must be kept confidential. It is not absolute and can be broken under a strict ethical-legal aegis but it represents the relationship of trust between the physician and the patient. Privacy, often applied as a synonym for confidentiality, can be defined as the right of the person to control information about themselves, thus guaranteeing human dignity [21].

Thus, respect for confidentiality is an expression of the dignity and autonomy of the patient and represents the duty of the physician to keep the information confidential [22]. Thus, breaking this bond of trust can be interpreted by the patient as betrayal, leading to the discredit of the professional and of medicine as a whole [23].

Considered a doctrine of respect for the person, medical confidentiality implies a strengthened physician-patient relationship, which is important for the professional, for the patient, and for society, with a strong characteristic of respect for autonomy. Extrapolating this ethical-moral issue and covering the medical-legal aspect, Flamínio Fávero defined medical secrecy as *the duty and right the doctor has to silence about facts of which he due to his profession* [24]. Such position is important because it addresses the perspective of the professional's duty as a legal issue and not just an ethical one.

In this sense, the *Hippocratic Oath* – written between the sixth and third centuries BC and

considered the milestone of the initiation of professional life in the area – is a reference for maintaining secrecy and is part of the good practices in medicine [25].

The oath brings with it the physician's obligation to keep secret the information "seen or heard" during professional performance and establishes as an occupational duty to respect the sick person's privacy. This obligation is not absolute and may be broken in situations of need. In the oath itself there is the prospect of relativization of medical secrecy – *And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets* [26] –, which is the standard of the principles of medicine [23].

The possibilities of breaking medical confidentiality are supported by ethical and legal determinations, varying between different countries. Physicians should be aware of these restrictions but should always prioritize respect for human rights by critically reviewing legal requirements and ensuring just cause for breach of secrecy [27].

Respecting the worker's privacy does not only mean not disclosing the private medical information that was obtained in a condition of trust but also represents an agreement signed between the worker and the physician, establishing the limits of this sharing of information [2].

The following are contributions from the codes of medical ethics as a guiding source of medical behavior on confidentiality.

Medical Moral Code, 1929

The theme is addressed in article 76 of chapter 9 and shows the importance of medical secrecy as an obligation that depends on the very essence of the profession since the public interest, the safety of the sick, the honor of families, the respectability of the physician, and the dignity of the art require secrecy. This code of morality is not restricted to physicians and surgeons, covering pharmacists, dentists, and midwives and explaining that secrecy must be guaranteed both in the circumstances *explicitly, formally, and textually entrusted by the client* and in situations resulting from it, even if not imposed, when related to the professional act. The disclosure of the secret is guaranteed within the ethical norms when the physician acts as an expert, declares infectious-contagious diseases to the health authority or prepares death certificates. As for occupational medicine, there is a reference to the physician *informing about the health of candidates sent for exams* [28].

1931 Code of Medical Ethics

This code has many similarities to the previous one. In the 1931 edition, the chapter on medical secrecy included 11 articles and no longer 13. Another change was the scope of article 77, which presents ten conditions which made it possible for the physician to reveal the secret: 1) as a witness in court; 2) in the functions of medical-legal expert and in the respective opinions; 3) when, as a physician of an insurance company, he officially communicates with the other physicians of the company; 4) in the health bulletin of men of notoriety, as long as he omits the diagnosis; 5) in the papers of the wards; 6) in death certificates; 7) in medical certificates; 8) in the notification of infectious-contagious diseases; 9) in prenuptial examinations; and 10) in health inspections in official communication with the respective medical authorities [28].

1945 Code of Medical Ethics

Chapter 9 includes five articles on the subject of medical secrecy. Article 35 contains the possible conditions for breach of confidentiality such as, among others, disclosure of secrecy when you are a witness in court, in medical certificates, in health inspections, and in communication with the respective authorities [28].

Code of Ethics of the Brazilian Medical Association, 1953

In this edition, there was a change in the understanding of the disclosure of medical facts in the situation of a witness, making explicit the impossibility of the physician revealing a secret of facts that he/she had knowledge in the exercise of their profession in this circumstance. According to Article 39, the disclosure of medical confidentiality is necessary in cases of infectious-contagious diseases with compulsory notification, or other compulsory notifications (occupational diseases, drug addiction, etc.) [28].

1965 Code of Medical Ethics

The chapter on medical secrecy, composed of 11 articles, maintains the determination of the necessary breach of secrecy due to compulsory notification of occupational disease [28].

Brazilian Code of Medical Deontology, 1984

Composed of six articles dedicated to medical secrecy, it abstains from aspects related to the worker and occupational disease but includes a chapter related to expertise and medical audit [28].

1965 Code of Medical Ethics

CFM Resolution 1,246/1988 repeals the 1984 edition, bringing new understandings, in line with the Federal Constitution of 1988, including, in article 105, the prohibition of *revealing confidential information obtained during the medical examination of workers, including by requirement of the directors of companies or institutions, unless silence endangers the health of employees or the community* [28]. Another aspect related to occupational medicine is found in article 11 (fundamental principles), which determined that *the physician must maintain confidentiality regarding confidential information of which he/she is aware in the performance of his/her duties. The same applies to work in companies, except in cases in which their silence harms or endangers the health of the worker or the community* [28]. Regarding medical responsibility, article 40 considers it an ethical infraction for the physician to *fail to explain to workers the working conditions putting their health at risk, and must communicate the fact to those responsible, to the authorities, and to the Regional Council of Medicine* [28].

1965 Code of Medical Ethics

Article 76 of the chapter on professional secrecy prohibits the physician from *disclosing confidential information obtained during the medical examination of workers, including by requirement of the managers of companies or institutions, unless silence endangers the health of employees or the community* [28]. Articles 12 and 13 prohibit the physician *from failing to explain to workers about the working conditions endangering their health, and he/she must communicate the fact to the responsible employers*, and from failing to explain to patients about the social [28], environmental or professional determinants of their disease, respectively [28].

1965 Code of Medical Ethics

Published nine years after the previous edition, this code maintained the previous understandings regarding workers [4].

Medical confidentiality in occupational medicine

The protection of employment and health, the rights to information and confidentiality, and conflicts between individual and collective interests are established in the International Code of Ethics for Occupational Health Professionals as the most prominent duties of a physician [2]. The ethical dilemma is established when the physician must choose an alternative affected by multiple variables, that is, when he must decide between at least two moral imperatives, neither of which is unequivocally acceptable nor preferable. Medical confidentiality is inserted in this scenario.

Compliance with the confidentiality of employee information is mainly ethical. The codes of medical ethics advocate respect for the worker but associated conditions must be imposed in this judgment, which, in ascending order, are: employer; occupational health and safety professionals; work environment; insurance and social security systems; family members of the worker; and society as a whole [29]. The network of those involved can generate distrust in workers regarding the exemption of the occupational physician, denoting their lack of knowledge about the functions of the professional who works in occupational health.

The mistaken understanding that occupational physicians have no therapeutic function – and, therefore, do not establish a relationship of trust with the worker, such as that which occurs between physician and patient – is easily contradicted. The occupational physician performs the function of caring for the health of workers, adapting the workplace, and referring employees to rehabilitation and physiotherapy, among other activities considered almost therapeutic [30].

Considering the participation in the medical care of observers not linked to the worker's care, an example of what occurs in situations for educational purposes, three conditions are mandatory: the worker's agreement; not compromising the quality of care and; the obligation of the observer to understand and agree with the medical standards of confidentiality [31].

The obligation of medical secrecy is not absolute and there may be a breach in situations of exception considered legitimate, in which disclosure is consented by the patient, required by law or in the public interest [32]. The worker's consent is only recognized by determining the interested party's ability to discern and the fact that it is a voluntary act. Moreover, it must be in writing and show all clarifications on the specific nature of the information, the purpose, to whom the information will be sent, the time period of data release, and the possibility of termination by the worker himself or his/her legal representative if he/she is unable [33].

The occupational physician may break with professional secrecy, according to the guidelines of the American Medical Association, in a manner similar to Brazilian standards, when there is written consent from the worker or his/her legal representative or in accordance with the required legal standards. In turn, disclosure of information should be restricted to the minimum necessary for the intended purpose and individual identification *should be removed before releasing aggregated data or statistical health information about the relevant population* [34].

Code of Medical Ethics

CFM Resolution 2,217/2018 [4], item 11 of the Fundamental Principles chapter, indicates the obligation of the physician to keep confidential information obtained during the professional activity. This principle makes direct reference to the *Hippocratic Oath*. In chapter 9, on professional secrecy, it is explained that medical secrecy is necessary but not absolute, and can be broken for a just reason, legal duty or written consent of the patient [4]. Thus, with the express authorization of the patient, the legal breach of confidentiality will not be discussed. However, the physician must ensure that the worker is able to exercise autonomy.

CFM Resolution 2,183/2018, which has specific rules for physicians who serve workers, establishes, in item 3, article 3, the obligation of the physician *to formally inform employers, workers, and internal accident prevention committees about risks in the workplace, epidemiological surveillance information, and other technical reports, provided that professional secrecy is protected* [35].

Along the same lines as CFM Resolution 2,183/2021 [35], CFM Resolution 2,297/2021 [36] states that the occupational physician is obliged to maintain the confidentiality of the information provided to the attending physician in an occupational risk report. This document must be delivered to the worker or his/her legal representative in a sealed envelope, as stated in paragraph 4, item 4, of article 1. Information from the worker's assistant physician may be requested by the occupational physician and will follow the same strict confidentiality standard. Article 15 states that in *lawsuits, the expert physician may petition the Court to officiate the health establishment or the assistant physician to attach a copy of the expert's medical record in a sealed envelope and in confidential nature* [36].

CFM Resolution 2,297/2021 [36], article 1, item 4, establishes the possibility for the occupational physician to discuss a clinical case with the employee's assistant physician to adapt the workplace to the clinical manifestations present. However, this does not exempt the worker's authorization [30]. The provision of information about the worker's health conditions is included in the resolution with a clear demonstration of the need to maintain a medical conduct that preserves the confidentiality of the information provided during the work of the occupational physician [36].

As for the legal duty, the main reference is the compulsory notification, as established by CEM [4] as a possibility of breach of confidentiality. Moreover, Law 6,259/1975 determined the obligation of the physician to communicate to the health authority a suspected or confirmed case of disease or event according to the list published by the Ministry of Health [37].

The notified conditions will be directed to the Notifiable Diseases Information System (Sinan) *of the Ministry of Health and the communication of occupational accidents* (CAT) *can be carried out by virtual means. According to the Sinan record, all events in the following situations must be considered occupational accidents:*

For non-natural causes comprised of accidents and violence (Chapter 20 of ICD-10 V01 to Y98) *which occur in the workplace or during the exercise of work when the worker is performing activities related to his/her function or at the service of the employer or representing the interests of the same* (typical) *or on the route between the residence and the work* (route) *which causes bodily injury or functional disturbance, which may cause the temporary or permanent loss or reduction of capacity for work and death* [38].

Article 22 of Law 8,213/1991 [17] determines that an accident at work must be reported to Social Security. In case of death resulting from the accident, the notification must be immediate, that is, up to the first business day following the event. The CAT must be completed only electronically, according to Ordinance 4,334/2021 [39] of the Ministry of Economy.

The legal duty related to compulsory notification is also expressed in CLT [40], in its article 169, with a new wording given by Law 6,514/1977 [40], which states that the physician must notify suspected or confirmed diseases associated with work conditions.

Finally, in its article 76, the CEM makes clear the physician's ethical duty to maintain the confidentiality of worker information, even when required by managers of companies or institutions, *unless silence endangers the health of employees or the community* [4], that is, due to a just cause.

Another issue to be observed refers to violence against women. According to article 1 of Law 10,778/2003, *cases in which there is evidence or confirmation of violence against women treated in public and private health services are subject to mandatory notification throughout the national territory* [41]. In the face of evidence or confirmation of violence suffered by the female workers, regardless of the place of occurrence, the occupational physician must report the fact to the police authority and carry out the compulsory notification, even without the woman's authorization. Disregarding the worker's will can generate conflict but the legal norm establishes the obligation of this medical conduct, justified by the need to protect women as an achievement of society [41].

The third possibility, according to CEM [4], of breaking with the worker's secrecy would be just cause. Of all the conditions allowing the breach of medical confidentiality without characterizing illegality, the most conflicting is just cause as it is a complex condition surrounded by subjectivity. For França, just cause arises from a *moral or social interest that authorizes non-compliance with a rule, provided that the reasons presented are relevant to justify such violation and is based on the existence of the state of need* [42]. Noronha, cited in Opinion 11/2001 of the Regional Council of Medicine of the State of Ceará [43], adds that this condition is established when the revelation is the only means of conjuring current or imminent and unfair danger to oneself or to others, being, therefore, a case of necessity, which entails the *collision of two interests, and one must be sacrificed for the benefit of the other* [44], as referred to in the text of Cunha. According to Gonçalves, *to try to reach the fairest attitude, the physician needs to consider the damage caused by the inviolability of confidentiality and the damage caused by violation* [45].

Ratifying this problem in the face of the subjectivity of the rupture of medical confidentiality due to just cause, in 2006, Kipnis's study [46] opened margins for fervent academic discussions. According to the author, confidentiality should not be broken even in circumstances in which the life and health of others are seriously endangered by the patient's conduct. In Kipnis's text there is a reference that physicians have an obligation to prevent public risks but there would be no honor in breaking secrecy. The wrap revolves around a scenario in which the physician is faced with a dilemma about informing the wife (also his patient) of his patient that he is infected with HIV [46]. For Gibson [47], Kipnis' position is unsustainable since, among several other aspects, it breaks with the principle of equity (justice), and for Bozzo [48], the decision to break secrecy in this circumstance must be based on rational choice.

In the Penal Code of 1940 [49], article 154, it is stated that disclosure of professional secrecy due to just cause is not characterizable as a crime and that the active subject is every person by reason of function, ministry, office or profession and the taxable person is any person holding the secret given in confidence. Article 266 of the code states that a physician who fails *to report to the public authority a disease whose notification is compulsory* is a crime and Article 325 states that it is a crime to reveal or facilitate the disclosure

of secrecy that must remain confidential and has been obtained due to a professional position [49].

The Law of Criminal Misdemeanors, article 66, makes it clear that it is a crime for the physician to fail to communicate to the competent authority a crime of *public action that was known in the exercise of medicine, provided that the criminal action does not depend on representation and that the communication does not expose the client to criminal proceedings* [50], establishing another favorable condition for the breach of confidentiality due to just cause.

Likewise, it is up to the occupational physician to silence, in testimony, facts about which he/she has become aware during medical work if he/she is unauthorized by the worker, according to article 207 of the Code of Criminal Procedure [49], especially when the disclosure may criminally incriminate the worker, as established in the sole paragraph of article 73 of the CEM [4].

Provision of a copy of occupational medical records

Among the forms of breach of confidentiality, the occupational physician must pay attention to the release of a copy of the occupational medical record, which must follow the determinations of articles 89 and 90 of the CEM [4], to meet the request of the worker or his/her legal representative. When this is impossible, the request must be made in writing. The last edition of the CEM establishes that the copy of the medical record can be sent directly to the requesting judge and Article 773 of the Code of Civil Procedure determines that the *judge may, ex officio or upon request, determine the necessary measures to comply with the order of delivery of documents and data* [51]. Moreover, the sole paragraph of the article establishes that *the judge, when receiving confidential data for the purposes of execution, will take the necessary measures to ensure confidentiality* [51].

In circumstances involving criminal investigation, the medical information regarding the worker made available to the court has the prerogative of confidentiality restricted to the maintenance of the fundamental rights of the person investigated, according to article 3 B of Law 13,964/2019 [52].

Regarding the availability of a copy of the medical record to *comply with a court order*, it should be noted that, according to the Code of Medical Ethics [28] of 2009, this conduct would be possible only if the expert appointed by the court were interposed. However, the new CFM guidance meets the provisions of article 330 of the Penal Code, according to which it would be a crime of disobedience to fail to comply with *the legal order of a public official* [49]. However, this is a factor of conflict between ethical and legal duty when disregarding the autonomy of the patient/worker. However, it is necessary to consider that this determination may, according to the situation, expose medical information included in the judicial process, even if, as previously pointed out, the judge acts to maintain the confidentiality of medical information [51].

Safekeeping and disposal of occupational medical records

The ethical-legal importance of the patient's medical record is undeniable; it contains information related to the worker's medical history that was granted under confidential circumstances and belongs to the person who granted it. However, the document, physical or electronic, must remain under the custody of the professional or the institution where it was prepared.

Information concerning the medical conditions of the worker must be described in individual medical records, whether on paper or electronically, which must be filed safely and kept for a minimum period of 20 years after termination of the public servant. This period is also mentioned in Regulatory Standard 7/2003, of the Ministry of Labor, when referring to the worker's medical record:

7.4.5. The data obtained in the medical examinations, including clinical evaluation and complementary examinations, the conclusions, and the measures applied must be recorded in the individual clinical record, which will be under the responsibility of the coordinating physician of the Occupational Health Medical Control Program [PCMSO].

7.4.5.1. The records referred to in item 7.4.5 shall be kept for a minimum period of twenty (20) *years after the termination of the worker* [54].

This understanding regarding the time to file the medical record is extended to the

Research

care segment, according to CFM Resolution 1,821/2007 [54], which also establishes the mandatory level of safety assurance two when the option is by electronic means.

Law 13,787/2018 [55] also determines that the electronic medical record must be kept for a period of 20 years, which can be changed if there is another regulated understanding – to be research material or for legal and evidentiary purposes, for example. This law also states the possibility of the medical record being returned to the patient if its destruction is indicated and, although it does not particularly refer to the occupational medical record, this deliberation can be applied to occupational medicine [55]. Considering specific work activities, such as exposure to asbestos dust, medical records should be kept for at least 30 years after the last note or until the worker turns 75, and for 40 years in the case of a worker exposed to carcinogenic chemicals [53].

Responsible for the confidentiality and custody of the medical record

The technician responsible for the worker care health unit and the coordinating physician of the PCMSO must keep the workers' medical records safe, and they are responsible for keeping the documents. In the event of a change of the technician in charge, a Term of Transfer of the Custody of Documents and Files must be issued, passing the responsibility to the successor physician; if there is no successor, the documents must be made available to the worker or be sent to the Regional Council of Medicine of the jurisdiction in which the document was formulated [53].

Françoso Filho, in Opinion 80,157/2015 [56] of the Regional Council of Medicine of the state of São Paulo, explains that, in case of transfer of an employee to another workplace, the original occupational medical record should not be sent to another physician, only its copy, when necessary, since the medical record cannot leave the institution responsible for its preparation and custody [56].

The breach of confidentiality can also be discussed in relation to the Social Security Professional Profile (PPP), an instrument proving the exercise of a special activity by the worker who is part of the occupational medical record. CFM Resolution 1,715/2004 [57] guides the occupational physician to observe all ethical care ensuring the maintenance of confidentiality in the preparation of the PPP, also prohibiting him from disclosing occupational health information to the employer or the company [57]. This resolution directs that the PPP field entitled "Results of biological monitoring" is not filled out by the occupational physician, as set out in article 268 of Normative Instruction 77/2015 of the National Institute of Social Security [58].

Final considerations

Decree 20,931/1932 [59] established a penalty in case of serious misconduct in the practice of medicine, imposing on the physician the need to permanently update himself on ethical and legal issues. The protection of confidentiality is a way of respecting universal human rights. However, situations of conflict may arise in the practice of occupational medicine, making it necessary for the occupational physician not only to know and obey ethical dictates but also, essentially, to follow legal norms. This study sought to show the main updated ethical and legal aspects related to occupational health and has its importance in helping all those who are dedicated to this very relevant area of medical knowledge.

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