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Shouldn't Confidentiality Transcend Death?

Following a recent death of a celebrity, social media goes into hyperdrive. Social media influencers pour in their tributes; mass media recreates the scene of his death; mainstream news anchors interview potential people who are informants and gently speculate the homicide angle to the death; while vested powers argue with each other to derive potential political mileage from the incident. Parallely, the nation is intrigued, and the medical records (including psychiatry diagnosis) along with the sensitive personal history of the deceased person, including “alleged” use of licit and illicit substances, are paraded as breaking news on primetime television. An “expert” panel (read as jury) debates the possibilities, and the TRP ratings of the news channels peak again after the nation had lost interest in the sensational reporting of the COVID-19 pandemic.

Time and again, a sensational homicide or a celebrity suicide captures the attention of the nation. After this wave of interest, the mass media feeds the audience's inquisitiveness with prime-time coverage of the deceased person's death and its repercussions. Although one could argue that the very business model of the media is based on the demands of the consumer, it is of utmost importance to uphold the boundaries of ethics and confidentiality, failing which the lines between transparency and voyeurism become blurred. The breach of a deceased patient's confidentiality can malign the deceased, his/her well-wishers, and have larger repercussions in the society. Additionally, such negative publicity for the mentally ill can potentially promote stigma and further hinder the access of a person with mental illness to healthcare.

All information is sub judice when it comes to ongoing investigations. All citizens, including doctors, should and must cooperate with all administrative and legal bodies as per the law of the land. However, it is baffling and sad that such confidential expert opinions and privileged communications are accessed quite easily and made available in the public domain.

Patient Confidentiality in Psychiatry

Although the patient–doctor relationship has become utilitarian, ethics and confidentiality relating to patient care are perhaps as old as the medical profession itself. Confidentiality can be breached



for judicial reasons or to protect other members of society.¹ If confidentiality is viewed strictly as a time-bound legal obligation, one can wonder if confidentiality agreements lapse with the death of the patient!² Such a reductionist view of the patient–doctor relationship as a business agreement can indirectly imply that there is a lapse of the terms of the agreement after the death of the patient

The confidentiality right of any patient is never absolute.³ This is particularly true for psychiatry practice, given the higher possibility of the doctor being made aware of sensitive information that can have ramifications for third persons and society at large. A golden rule imbibed in

psychiatry ethics regarding confidentiality is that ‘The right to confidentiality ends when a threat to life begins.’ Confidentiality agreements in psychiatry are breached when the doctor foresees a danger to life (patients or others) and when necessitated by the law (such as POCSO: Protection of Children from Sexual Offences Act). Although confidentiality and its issues in psychiatry research is another important gamut,⁴ the ethics of confidentiality breaches when there has been no threat to life or society are not so grey.

Who Should Protect the Rights of the Deceased Mentally Ill?

This brings us to the next question on who should protect the confidentiality rights of the deceased mentally ill. Although the answer to this question is sufficiently complex, the stakeholders involved in protecting the rights of the deceased involve healthcare professionals, civil society, judiciary, media, and the executive, among many others. Doctors play a pivotal role in upholding and promoting such rights.

The Declaration of Geneva,⁵ which builds upon the Hippocratic oath, contains two declarations among 11 that are of paramount importance in this scenario:

“I will respect the secrets that are confided in me, even after the patient has died.”

“I will not use my medical knowledge to violate human rights and civil liberties, even under threat.”

These two statements serve as a clarion call for all psychiatrists (and the broader medical fraternity) to respect the confidentiality of the deceased and to maintain and uphold the highest standards of medical ethics in our profession.

Conclusion

A deceased patient's right to medical records, despite the presence of ongoing

ing legal investigations, will remain a privileged communication between the doctor, the deceased, and the administrative/legal agencies. The presence of such information in the public domain and the continued dissection thereof violates the sacred right of the deceased.

It is the prerogative and necessary responsibility of the medical fraternity to defend this right of the patient, alive or not, for now, and for the days to come.

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Adult Onset Rasmussen's Syndrome Presenting with Psychosis

Theodore Rasmussen and his colleagues first described his eponymous disease in 1958, in three children with a longstanding illness causing focal seizures and worsening damage to one cerebral hemisphere. Rasmussen's encephalitis, also called Rasmussen's syndrome, is a progressive disease characterized by drug-resistant focal epilepsy, progressive hemiplegia, and cognitive decline, with unihemispheric brain atrophy.¹

The syndrome has been divided into three clinical stages. The first is the prodromal stage, with a median duration of seven months (range: 0 months to 8.1 years), a low frequency of seizures and mild hemiparesis. The acute stage, which comes next, has a median duration of eight months and is characterized by frequent seizures. It is accompanied by prominent neurological signs like worsening symptoms of hemiparesis, hemianopia, and cognitive deterioration. The involvement of the dominant hemisphere may lead to aphasia. The last stage is the residual

stage with irreversible damage and less frequent seizures than in the acute stage.^{2,3}

Though considered as an illness of childhood, adult and adolescent patients account for 10% of all cases.² This report describes the complex case of an adult patient who presented with psychosis as a sequela of Rasmussen's encephalitis.

Case Details

A 32-year-old man came to the outpatient department accompanied by his father, with complaints of withdrawn behavior, unprovoked anger outbursts, occasional smiling to self, poor comprehension, and delayed response for 13 years. According to the informant, the patient had achieved developmental milestones at the appropriate ages. He was reported to have a well-adjusted premorbid personality, has been able to handle all his responsibilities, and was pursuing graduation when the symptoms started. One month prior to the onset of symptoms, the person had a high-grade fever with multiple episodes of sudden onset of abnormal movements of all the four limbs, loss of consciousness, frothing at the mouth and incontinence, for which he had received inpatient treatment. Fol-

lowing discharge, he was prescribed T. sodium valproate 1500 mg in two divided doses, with which the frequency and severity of the seizures decreased.

The last episode of seizure was eight years back. After five years of remaining seizure free, the antiepileptic medication was tapered and stopped three years back. He also had left sided weakness, which improved gradually but never recovered completely. However, throughout these last 13 years, the patient had been withdrawn, made no verbal communication, and sometimes used gestures to communicate. He was often noticed to be smiling or muttering incomprehensibly by himself. He seemed to have poor comprehension of instructions and had a slowing of response. He also had episodes of unprovoked aggression toward family members and outsiders. He had received trials of risperidone and olanzapine in adequate doses in the past, with unsatisfactory response.

He had resting tremors bilaterally. The left upper and lower limbs had hypertonia and hyperreflexia. An equivocal plantar response and ankle clonus were observed on the left side. Romberg's test was positive. There was no aniso-