PJP

CASE REPORT

EXAMINATION OF THE RIGHT TO CONFIDENTIALITY

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ABSTRACT

With the establishment of the Republic Act No. 11036, more popularly known as the Mental Health Act, improvement in the mental, neurologic, and psychosocial health took a step forward in the Philippines. This law, which was signed on June 2018, gave specific provisions in different aspects of delivery of mental health services to Filipinos. This law proved very useful in the dilemma faced in the following case where a potential problem in confidentiality was encountered.

CASE PRESENTATION

Chief Complaint

N.O. is a 15-year-old, Filipino Catholic adolescent female, an only child of her parents' union but the youngest among 4 children on her father's side and the youngest of 10 children on her mother's side, presently residing with her parents. N.O. was brought for consult by her mother due to persistent headaches and difficulty in sleeping.

History of Present Illness

Two years prior to consult, when N.O. was 12 years old, she was allegedly raped by her 22-year-old neighbor. They were chatting online for a few weeks until she was invited over to his house because he said he would give her a surprise gift. Intrigued, she sneaked out one night and went over to her neighbor's house. She was led inside his room, forced to lie down on the bed, disrobed, and was under the control of her neighbor. During that time, the patient felt helpless and scared. She did not know what to do and even failed to fight her neighbor. When it was over, she was warned not to tell anybody of the incident or else she would be harmed. Fearing for her life, she went back to her house without saying anything to her family. She blamed herself. She felt alone. Since then, she was noted to be more quiet than usual and was easily startled, prompting her half-brother (A.O.), who came to visit their parents several days after the alleged incident happened, to ask the patient what was happening to her. She confided to A.O. but pleaded with him not to say or do anything. He promised and instead, helped her out in determining if she got pregnant by using a pregnancy test. Negative results were noted, and the 2 siblings decided to be quiet about it for the meantime. She went about her usual activities. She attended her classes without fail and consistently garnered high grades. However, she would occasionally have difficulty in concentrating at school. At home, she was terrified at the possibility of encountering her neighbor. She was able to take comfort in the fact that she was not allowed to go outside the house without being accompanied by either one of her parents and so she stayed home most of the time. She would have frequent dreams about her neighbor and the alleged incident. She would distance herself from her half-brother because she would remember the alle-

-ged incident. No problems were noted until a few weeks after when she was fed up with a classmate teasing her and so tried to choke him. She felt it was unfair when she was reprimanded. Despite this, N.O. was still able to maintain high grades and was at the top of her class but later the patient was dropped from the 1st rank of the class due to her English subject. She felt betrayed because she was usually the favorite in her class. In secret, N.O. would scratch her arms or would think of hurting herself because she felt that she was humiliated. She attempted to slash her wrist but was prevented by her half-brother. She was then transferred to another school after her parents' unsuccessful attempts to plead with the patient's teacher to give her some consideration.

N.O. was initially faring well academically in her new school but 1 year prior to consult she punched a classmate due to his relentless teasing. She felt ill-used when she was reprimanded. She was obedient and well-liked by her teachers, but she was blamed for the incident regardless of the teasing by her classmate. Since then, the patient again felt that she did not belong in her school because they seemed afraid of her. Still, her grades were not affected even if she would have some difficulty in concentrating while in class.

At another time, the patient informed her parents that she would be a little late in coming home from school because of a school project with her classmates. However, her parents found out that she and her classmates went to a mall near their school. Her parents, most especially her father, got very mad and scolded the patient and her classmates. She had a big fight with her father and wanted to die because no one really understood her, not even her father. She took 2-3 tablets of Trimetazidine (her father's medication) when she was stopped by her mother and brought to the hospital. She was observed and was sent home with no complications. She promised her parents that she would not hurt herself again. She went back to her usual activities, but was more closely monitored by her parents. Her feelings of loneliness and isolation persisted but she tried to divert her feelings.

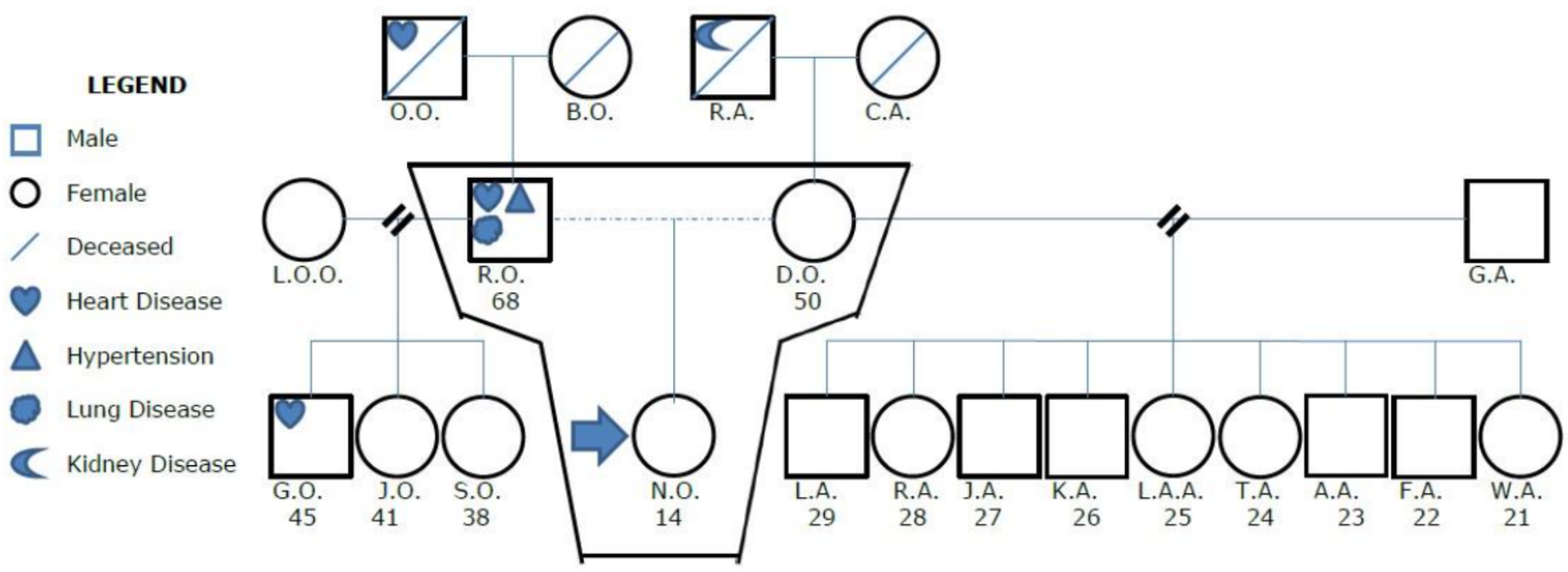
About 2 months prior to consult, she was told hat she would be transferred to her old school because of financial constraints. She did not want to return but she had no choice but to agree despite being very apprehensive about it. With the prospect of going back to her old school, she started to have more frequent dreams about her alleged sexual assault 2 years ago, though unable to recall some parts of the alleged incident. During this time, N.O. would see her parents frequently fighting about their financial problems. She feared that they would separate and leave her. Since then, the patient was noted to be easily irritated and quieter. She would scratch her forearms to relieve stress and release her tension. She would occasionally think of what it was like to die but at the same time was afraid to try killing herself.

One month prior to consult, N.O.'s father underwent a major surgery. She was very worried about her father as they were very close. She felt guilty that she burdened him with her problems. She started thinking about what happened to her 2 years prior. Her dreams about the alleged incident became more frequent. She wanted to tell her father but she was too afraid of his reaction. She felt ashamed and guilty of not having told her father of what happened. N.O. started to have frequent headaches and difficulty in sleeping. She had difficulty concentrating. Her mother noted that N.O. had frequent blank stares. The patient would get distressed about feeling that she did not belong in her family and in her community as if she was a ghost.

Two weeks prior to consult, headaches became more frequent and persistent, with pain scores of 6-7/10, prompting her to seek consult in the emergency section of the Pediatrics department, where she was prescribed with Mefenamic acid 500mg/tab, 1 tab every 6 hours and Vitamin B complex 1 tab once a day. No relief of symptoms were noted with the medications. She was very frustrated up to the point that she wanted to die. She was referred to Psychiatry in the ER due to her difficulty in sleeping. At that time, she was noted to be depressed with congruent affect. She was anxious and was hesitant to relate her feelings. She denied any history of trauma or abuse. Initial impression was Persistent Depressive Disorder; with Borderline Personality Traits and Suicide Risk. She was prescribed with Sertraline 50mg/tab ½ tab ODHS and Alprazolam 500mg/tab ½ tab PRN for insomnia. They were advised to follow-up after 1 week.

Family and Social History
There were no known psychiatric illnesses in the family. There was hypertension and heart disease on her paternal side, while dyslipidemia and kidney problems on her maternal side. She was a non-smoker and never used illicit drugs. She occasionally drank wine (1-2 times a year, half a glass) with her last intake a year prior to consult.

Family Genogram



Father: R.O., 68 years old
He was a retired military pilot, who eventually worked in the real estate sector. Before he became ill, he was involved with real estate that occasionally entailed going abroad to work on projects. One month prior to the patient's consult, he was admitted due to hemothorax and underwent bullectomy and lobectomy.

He had 3 children from his former common-law wife who all live in the United States, thus have a strained relationship with R.O. With his 3 children, he was very strict and authoritarian, especially when he was still in the military. He was easily angered and used corporal punishment in disciplining his children. He separated with his common-law wife when she went to work abroad.

He allegedly and impulsively shot a person point-blank while the said person was drinking with his friends immediately after discovering that his daughter (the patient's half-sister) was bullied by that person. Patient's father then went to the police station because the person that he killed reportedly had a cousin who was a police officer and also shot the police officer.

The matter was smoothed over because R.O. had money at that time, thus he was not arrested or jailed. He met his wife, the patient's mother, when he was still in the military. When the patient was born, he was observed to have apparently changed. Athough still short-tempered, he could be pacified by his wife.

He doted on the patient and not once did he hit her. Lately, patient's parents would be heard bickering mostly about money, which would alarm the patient, thinking that her parents were going to separate.

Mother: D.O., 50 years old
She was a real estate agent who had a previous common-law husband with whom she had 9 children; 2 of whom are close to the patient (J.O. and A.O.). She separated from her first husband due to undisclosed reasons.

She was described as talkative, frank and short-tempered. She also allegedly stabbed a person who attempted to pick a fight with her. Like her husband, she doted on the patient and gave her whatever she asked for and was the one more easily swayed by the patient.

Half-Siblings on the Paternal side:

1. G.O., 45 years old, married and currently living abroad. He has no relationship with the patient and has a strained relationship with his father.

2. J.O., 41 years old, married and currently living abroad. She has no relationship with the patient and also has a strained relationship with her father.

3. S.O., 38 years old, married and currently living abroad. She would come and visit every year, bring gifts to the patient and allowed the patient to have a sip of wine with her during dinner.

Half- Siblings on the Maternal side

All of the patient's siblings with her mother are living with their father in the province. They do not visit their mother in Quezon City due to the strained relationship between their father and the patient's mother. Only J.O. and A.O. would come by and stay for a few days with N.O. and her parents.

1. L.A., 29 years old, currently working in the province. He has no relationship with the patient.
2. R.A., 28 years old, currently working with his brother, L.O. in the province. He has no relationship with the patient.
3. J.A., 27 years old, employed in Quezon City, currently living in an apartment. He would sometimes visit his mother and half -sister for a few days. He would play and talk with the patient and was like one of the patient's close friends.
4. K.A., 26 years old, working in the province. He has no relationship with the patient.
5. L.A.A., 25 years old, married and lives in the province. She has no relationship with the patient.
6. T.A., 24 years old, working in the province. She has no relationship with the patient.
7. A.A., 23 years old, employed in Quezon City, currently living in an apartment. He would occasionally visit his mother and half -sister for a few days where he would play and talk with the patient and also considered as one of the patient's close friends. Patient is closer to A.O. as he was the first one to know of her alleged rape 2 years ago.
8. F.A., 22 years old, currently working in the province. He has no relationship with the patient.
9. W.A., 21 years old, working in the province. She has no relationship with the patient.

Developmental & Social History

N.O. was born term and without complications to her then 35 -year-old G10P9 (9009) mother via Normal Spontaneous Delivery at a private hospital. Her mother had regular prenatal check-ups. She took Ferrous Sulfate during the 2nd trimester of pregnancy. The pregnancy was planned and wanted. Mother's emotional and physical states were unremarkable, with no history of trauma, substance abuse, and intake of teratogenic drugs. She reported bleeding during the 3rd trimester of pregnancy which turned out to be due to placenta previa, which resolved eventually. No other complications were noted throughout pregnancy. N.O. was immediately mixed fed with breastmilk and formula milk until 3 months because of decreased maternal milk output. She was fed immediately as per demand. No eating problems were noted. The mother was the primary caregiver. Developmental milestones were noted to be at par with her age. She was attached to her mother and would cry when another person would carry her away from her mother. However, she would calm down after a few minutes and would respond happily to the person carrying her.

Moderately strict toilet training was enforced by the father, who would wake her up at night to go to the toilet. Accidents were dealt with verbal reprimands by the father most of the time and embraces and kisses from the mother whenever she would pee accidentally. Toys were bought almost always. She would throw a fit when her wants were not met, and she would calm down with the reassurances of her parents. She was shy towards neighbors but active at home. She often played alone or with her half-brothers, because her parents did not allow her to play outside.

The first memory of N.O. was when she was 5 -years-old happily eating together with her parents. She was enrolled in a preparatory class near her home. She was an active and smart child, and got along with her peers. On the 1st day of 1st grade, she was anxious to be left alone by her mother that she had to be reassured of mother returning after class. She was a top student during her grade school and

was tutored by both parents who encouraged her to get high grades. Many of her classmates were her friends but was not open to share her feelings with them. Her activities were limited to school and home because her parents did not want her to play outside the house.

At home, she would play with 2 of her half-brothers. The rest of her siblings were away and had little to no interaction with her. She would ask about them, but she would be told not to mind them because she was their priority. Discipline was enforced by both parents, but lax. The father was firmer in his decisions with regards to the patient. However, both would waver and give in to the patient most of the time. She transferred to another school after finishing Grade 7 then returned for Grade 9. She was more at ease in her 2nd school but she was transferred back due to financial constraints. She was more of a follower than a leader. N.O. was one of her teachers' favorites thus often given special errands. She was not allowed to go out on her own with her friends and needed supervision by her parents. She spent most of her time at home, watching Korean movies or television series and spending time with her family. She liked to apply make-up and dress up.

Past Medical and Psychiatric History

There was no history of psychiatric consultations or hospitalizations. She was admitted twice for Dengue Fever and once for Urinary Tract Infection with no complications noted. She had an early menarche at 10, like her mother. Menstruation was irregular, consuming 2-3 pads/day, moderately-soaked, 3-4 days duration. She was nulligravid but with 1st sexual contact at 12 years old. No contraception was used.

Mental Status Examination

She was seen and examined as an adolescent female, medium built, dressed older for her age with tight-fitting top and leggings, and with slightly heavy make-up; fairly kempt and groomed. No behavioral oddities were noted, with fair eye contact. She was cooperative and fairly conversant. Mood was depressed, with appropriate affect. She had normo-productive speech, slightly slow rate and decreased tone of voice. She related that she was hearing buzzing sounds beside her ears. She admitted to feeling depressed but related that the difference this time was that she will get the help she needed. She denied suicidal or homicidal ideations. Responses were linear and goal-directed. She was oriented to 3 spheres, with intact memory; good concentration, calculation, fund of knowledge, abstract thinking, impulse control, and judgement. Insight level was III. She believed that she needed help because of what happened to her in the past.

Physical and Neurologic Examinations

Both physical and neurologic examinations revealed unremarkable findings.

Diagnosis & Differential Diagnoses

Diagnostic work-up was done to rule out a DEPRESSIVE DISORDER DUE TO ANOTHER MEDICAL CONDITION [293.83 (F06.31)], given that a general medical condition could cause behavioral changes must always be considered. The patient's symptomatology was able to fulfill Criteria A, D, E of the disorder: i.e. there was a prominent and persistent depressed mood (Criteria A); that the disturbance did not occur exclusively during the course of the delirium (Criteria D) as there was no report of fluctuations of attention and consciousness; and the disturbance caused clinically significant distress and impairment in her social functioning (Criteria E). However, she was not able to fulfill Criteria B and C i.e. there was no evidence that the disturbance was the direct pathophysiological consequence of another medical condition (Criteria B), as all laboratory work-ups done upon initial encounter were normal and she was cleared medically by the Pediatrics Department. Thyroid function tests were also done in her OPD consult, with normal results. In addition, EEG was done with unremarkable results. And for criteria C i.e. The disturbance could be explained by another mental disorder; thus this diagnosis was ruled out.

Thorough review of the patient's substance or drug use history was done, as well as a spot urine drug test, to rule out a SUBSTANCE-/MEDICATION-INDUCED DEPRESSIVE DISORDER [292.84 (F19.94)]. The patient belonged to an age-group with high potential for illicit drug use. The patient fulfilled Criteria A, D, and E. There was a prominent and

persistent depressed mood (Criteria A). The disturbance did not occur exclusively during the course of the delirium (Criteria D). The disturbance caused clinically significant distress to the patient and impairment in her social functioning (Criteria E). However, she was not able to fulfill Criteria B and C i.e., there was no evidence that the symptoms developed during or soon after exposure to a drug (Criteria B), as urine drug test was done with negative results. No other medications were taken by the patient that could possibly produce her symptoms and the disturbance could be explained by another mental disorder (Criteria C); thus, this condition was also ruled out.

Despite the depressive symptoms noted from the history, the patient was unable to fulfill Criterion A for MAJOR DEPRESSIVE DISORDER [296.24 (F32.3)]. She was only able to fulfill 4 out of the 9 symptoms: depressed mood, insomnia, diminished ability to think or concentration, and recurrent thoughts of death. Still, depressive symptoms could not be overlooked. A PERSISTENT DEPRESSIVE DISORDER (Dysthymia) [300.4 (F34.1)] was also initially considered but ruled out. Despite the symptoms of the patient, these were not apparent to have occurred for more days than not, as specified in Criterion A of the disorder. In any patient presenting with depression, it is important to probe for possible manic or hypomanic episodes (BIPOLAR I OR II DISORDER [296.40 (F31.9] / 296.89 [F31.81)]) in the past. In the case of the patient, no manic episode was noted.

First follow-up revealed hallucinatory behavior and a history of trauma. A trauma-related disorder was then considered. With the exposure of the patient to a traumatic event, as well the pattern of the patient upon longitudinal review of her history, a diagnosis of POST-TRAUMATIC STRESS DISORDER [309.81 (F43.10)] was highly considered and eventually made. The patient had a 2-month long history of intrusive symptoms (Criterion B), specifically recurrent distressing dreams about her attack, as well as intense psychological distress upon exposure to external cues reminiscent of her attack. She was also able to fulfill Criterion C in which she would avoid ex-ternal reminders of her attack. Criterion D was also fulfilled. She had dissociative amnesia as well as feelings of detachment and estrangement from others. Criterion E was also fulfilled. She had irritable behavior and angry outbursts at school and she also had problems with concentration and sleep disturbances. Her recurrent experiences of unreality of her surroundings necessitated the specifier of dissociative symptoms. This was ruled in.

BORDERLINE PERSONALITY TRAITS were also highly considered. Unstable sense of self, parasuicidal behavior, feelings of emptiness, episodes of physical violence, dissociative symptoms were noted. Although the patient presented with these manifestations, she could not yet be diagnosed with a personality disorder because these traits were not yet inflexible as required in the diagnosis of personality disorder 1. Despite this, it is important to be aware and to take noted of this because the stability of the personality traits needs to be assessed over time and across different situations. Borderline personality traits have been shown to develop to borderline personality disorder in time 2,3.

Course in the Clinic

N.O. revealed her alleged sexual assault on the 1st follow-up. She was started on Olanzapine 5mg/day due to disturbed and hallucinatory behavior. Dissociative amnesia was noted. She related her desire to tell her father, but her mother refused out of fear that he would kill the perpetrator. Subsequent follow-ups showed fluctuations between improvement and disturbed behavior, warranting increase in doses of Sertraline to 50mg/day and Olanzapine to 10mg/day. Improvement in symptoms were noted and Cognitive Behavior Therapy (CBT) was initiated with promising results. Olanzapine was discontinued in her last follow-up, with preparations for the patient to return to school.

DISCUSSION

Psychodynamic Formulation

Absence of delayed gratification is a common theme throughout the N.O.’s life as all her wants and needs were readily given by her parents. In addition, she was not exposed to relationships outside the family. Her parents both had problems in controlling their anger, thus were poor role models on handling emotions. This lack of “practice” for social interaction could be the reason for her apparent lack of close relationships. She did not know how to act or ad-just accordingly, leading to feelings of being bullied.

-Ultimately, when the time came that the family became financially challenged, she was unable accept or cope with the need to be deprived of her material wishes or frustrated of her demands. These restrictions were internalized by N.O. as a negative experience and became angry at her parents for not giving her what she wanted.

Aggressive feelings led to conflicting and confusing feelings within N.O. There was a clash between opposing pairs of internal object relations, that is, between having a good parent or having a bad parent. Prior to this, her alleged sexual assault took a toll on her. She blamed herself for what happened because she was the one who decided to sneak off to her neighbor' house. She was raped and humiliated. She was overpowered. She had no control of the situation. This humiliation might have devalued the patient as an individual, resulting to loss of self-esteem and self-worth. She might have been pushed over the edge when her father got sick since she had to take care of him. N.O. noticed how her father was transformed from being very functional and even aggressive to being weak and useless. Having introjected her father also, this loss of function and purpose reverberated within her. She was both angry and sad that her father was now helpless (loss of the father image as a constant pillar of strength and provision) while she now had to be burdened with taking care of him and giving up material benefits and her preferred school. Unconsciously, she may have also blamed herself for his condition. The guilt feelings that were with her for being sexually assaulted, for being angry at her parents because of their financial problems, all led to her blaming herself. Being subjected to the taunts of her classmates, to her perceived unjustified low grade that cost her top rank in class, her father's illness and recurrent financial troubles, reactivated that same sense of lack of control when she was sexually assaulted. She was helpless. The old trauma was reawakened by her recent troubles. Dissociative defenses came into play, trying to keep her intense and painful affects unconscious.

However, the prominence of the traumatic memories caused them to be maintained at a high state of cognitive activation. These factors led to N.O.'s memory intrusion alternating with memory failure. Instead of working through the painful memories, N.O. somatized her affects i.e. headaches, difficulty sleeping in order to avoid the powerful emotions, which were viewed as threats to her. That lack of control led to dissociation, which represented N.O.'s failure to integrate aspects of her perception, memory, identity, and consciousness. It gave her a sense or illusion of psychological control.

Management

Biological: The possibility of admission was discussed with the mother if the patient's behavior would escalate at home. She was thoroughly informed, and her decision was to keep a close watch on the patient instead. The patient was maintained on the following: (1) Sertraline 50mg/tab 1 tablet ODHS- Antidepressants have been used as adjuncts to psychosocial treatments and Sertraline is approved by the FDA 4,5 in the treatment of PTSD in adults, but with scant evidence to support the use in the youth. Still, several studies 6,7,8 would show that SSRIs have moderate effects in PTSD. (2) Olanzapine 5mg/tab 1 tablet ODHS. An antipsychotic was given and eventually discontinued to address the hallucinatory behavior of the patient as reported in the course of her follow-ups. (3) Alprazolam 500mcg/tab 1 tablet as needed for anxiety and difficulty sleeping.

Psychological: Cognitive Behavioral Therapy i.e. psychoeducation was conducted for the parents and the patient. Knowing the low frustration tolerance of the patient, parents were guided on their parenting skills, e.g. on when to say no to the patient, not giving in to demands and wants all the time. The patient was encouraged to do relaxation techniques, and to identify her feelings and talk about it.

Social: Safety of the patient was the most important consideration. Given that the alleged perpetrator was still living nearby, it was discussed with the mother on how to ensure the safety of the patient and whether patient could live physically far from the alleged perpetrator. However, it was not possible at the time for the family to transfer residence. The mother made the initiative to talk to the perpetrator and his family, warning against any interaction with the

patient. A threat of filing a case or a police report was discussed with the perpetrator and his family. For the patient, the mother was contemplating on having her on close watch by herself or, if she could hire a nanny, to watch the patient while she was away. Strong community support was also discussed. The reputation of the parents in the community could also be harmful to the patient. Outside school, the patient also had limited social interactions in the community. Both issues were thoroughly discussed, and steps were taken to start to expose the patient to the community. Although the patient was not able to identify any friends in her school, she admitted that she had a few friends before in the neighborhood and she verbalized the desire to rekindle the relationships.

Dilemma on Confidentiality

Establishing rapport could not be over-emphasized in this case. The first encounter proved that several meetings were needed to fully establish the trust between a doctor and a patient. With N.O. opening about the trauma she experienced; it was decided that on her sub-sequent follow-ups, a more focused and guided approach would be utilized.

In addition to her medications, the need for N.O. to work through her trauma was deemed of utmost importance. And one step identified, as volunteered by N.O., was to inform her father of what happened. However, her mother was against the idea out of fear that he would kill the alleged perpetrator as well as his entire family, given his history. The father, when hypo-thetically asked what he would do if such incident would happen to his daughter, admitted that he would hunt and kill the perpetrator without any regard for what will happen to him.

Given such a situation, what should a reasonable psychiatrist do? We turn to the Mental Health Act (Republic Act No. 11036) 9. In Chapter II, Section 5 (Rights of Service Users), one of the rights identified was: (l) “Confidentiality of all information, communications, and records…shall not be disclosed to third parties without the written consent of the service user concerned or the service user’s legal representative, except in the following circumstances:…(3) A life-threaten-ing emergency exists, and such disclosure is ne-cessary to prevent harm or injury to the service user or to other persons.” With the examination of this provision, it was N.O.’s decision herself to disclose the information to her father. However, being a minor, her mother served as her legal guardian who was against the N.O.’s wishes. Ideally, the patient should be encouraged to inform her father with the intent of relieving N.O. of her guilt. Yet if the patient would tell her father, there was a chance of assault towards the alleged perpetrator.

Furthermore, examination of the Mental Health Act showed that informing the father would serve as a breach of confidentiality as specified in Section 5l and the psychiatrist may be held criminally liable as stated in Section 44 9: “Penalty clause: Any person who commits any of the following acts shall… be punished by imprisonment… or a fine…, or both, at the discretion of the court..”

The mother can file for a criminal case of breach of confidentiality against the doctor, since she specifically told the doctor not to tell the father anything about the rape incident. Should this happen, the burden would be for the doctor to prove his or her own innocence in court. Given that there is that chance of harm to the alleged perpetrator, is it warranted to warn him? One case comes to mind: Tarasoff v. Regents of the University of California (1974) 10. In this case, it was held that mental health professionals did have a duty to protect individuals who were being threatened with bodily harm by a patient.

However, the father was the one who made the threat. Despite the father’s statement, the threat was not in absolute terms. Also, the patient’s father was not the patient. The psychiatrist has no technical responsibility in preventing him from enacting his threat. There is no provision in the Act stating an explicit duty to inform another person of a threat of harm (in contrast to the Tarasoff case). It rather only creates an exception to the patient’s right to confidentiality and thus, the only obligation to the patient’s right to confidentiality under it, was to not violate that confidentiality. In consideration of N.O., the need to inform the father was examined. If the father would be informed of the rape incident, the guilt feelings of N.O. would possibly be unloaded.

At the same time, if the father indeed would kill the neighbor and his family, a crime would be committed, and the patient might suffer more with the burden of death of several people. N.O. ultimately has the right to inform her father or not. The role of the psychiatrist was not to influence or force the patient.

CONCLUSION

Physicians, in general, sometimes have the difficult task of balancing a decision that will be beneficial for the patient or to the family or even the public. Now with legal implications for every decision in a patient, the Mental Health Act will serve as a guide for physicians in considering the welfare of their patients and the community. In N.O.'s case, the decision to give out or withhold the information rests on the patient. The role of the psychiatrist is to discuss the pros and cons of such "telling", providing support for the patient and letting her decide for herself without undue influence from the doctor.

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