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Tarasoff down under: the psychiatrist's duty to warn in Australia

BY DANUTA MENDELSON, M.A., PH.D., LL.B. (HONS.) AND GEORGE MENDELSON, M.B., B.S., M.D., F.R.A.N.Z.C.P.

The authors discuss the differences between the U.S. and Australia in legal approach and in the codes of medical ethics to the issues of medical confidentiality and disclosure as represented by the Tarasoff case. It is argued that in Australia, a psychotherapist would not be justified in breaching his duty of confidentiality towards a patient. The ethical codes that govern clinical practice in Australia, and the common law, focus primarily upon the therapeutic relationship between the doctor and the patient, virtually excluding any considerations extraneous to that relationship.

In 1969, Prosenjit Poddar, a graduate student at the University of California, informed his psychotherapist, Dr. Moore, that he intended to kill on her return home from holiday in Brazil an unnamed but identifiable girl, Tatiana Tarasoff.

When Dr. Moore found out that Poddar had purchased a gun, he notified the campus police that he intended to arrange for civil commitment of Poddar under a 72-hour emergency psychiatric detention provision of the relevant California statute. However, having apparently secured from Poddar a promise that he would avoid Tatiana, the campus police decided not to detain him. After Tatiana's return from Brazil, Poddar, armed
with a pellet gun and a kitchen knife, went to her residence and fatally stabbed her.

Tatiana’s parents brought an action for wrongful death against the Regents of the University of California, the campus police and the therapist, claiming, inter alia, damages for “failure to warn of a dangerous patient.”

The causes of action against the University Regents and the police were blocked by governmental immunity. However, the California Supreme Court decided on December 23, 1974, in the case known as Tarasoff I, that Poddar’s therapist could be held liable for his breach of duty to use reasonable care to give threatened persons such warnings as are essential to avert foreseeable danger arising from his patient’s condition and treatment.

Thus, by deciding that the plaintiffs had a cause of action against Dr. Moore for breach of duty to warn Tatiana, the court imposed upon therapists the duty to warn potential victims. Yet, at common law as a general rule:

There is no duty so to control the conduct of . . . a person as to prevent him from causing physical harm to another.

The jurisprudential genesis of the Tarasoff I “duty to warn” cause of action appears to lie in one of the exceptions to the above rule, according to which a doctor who has custody over the patient and who through his conduct creates or contributes to the patient acting in a manner endangering the welfare of a third party may come under the duty of care towards that third party. The doctor’s duty of care towards the third party would involve his taking a positive action to control the patient. In the case of Tarasoff I, the court stated that:

. . . following Poddar’s encounter with the police, Poddar broke off all contact with the hospital staff and discontinued psychother-
apy. From those facts one could reasonably infer that the defendants' actions led Poddar to halt treatment which, if carried through, might have led him to abandon his plan to kill Tatiana, and thus that defendants, having contributed to the danger, bear a duty to give warning.6

In its statement the Supreme Court of California extended the traditional parameters of control, which had been defined with reference to custody and powers of in loco parentis, by assuming that doctors and therapists5 have the ability to control their outpatients. The court then proceeded to infer that the failure by Dr. Moore to effectively hospitalize Poddar, or to "hold on" to him as a patient, amounted to a wrongful conduct on the therapist's part not only towards Poddar as his patient6 but also toward Tatiana. When, through his ineffective attempt at Poddar's hospitalization, Dr. Moore lost the opportunity of exercising control over Poddar, whom he knew to pose danger to Tatiana, he lost the chance to prevent or to minimize this danger through therapeutic treatment. This lost opportunity to treat brought Dr. Moore into a special relationship with Poddar's potential third-party victim, Tatiana, which relationship entailed a positive duty to warn her.7

The principle that a positive duty of care towards a third party may arise out of the doctor's failure to control a patient within a custodial relationship is relatively well established; however, the Supreme Court's interpretation of the content of this kind of duty in the context of a non-custodial doctor/patient relationship was rather novel. In strictly legal terms, according to Tarasoff 1, a doctor who breached a duty of care towards his patient by not controlling his dangerous proclivities, and who thereby was brought into a special relationship of care with an endangered third party, then had to breach another duty towards that same patient—the duty of therapeutic confidentiality—in order to fulfill the positive duty of care that arose between himself and the third party.
The defendant therapist, together with several amici curiae, including the American Psychiatric Association, the California State Psychiatric Association, the San Francisco Psychoanalytic Institute, the National Association of Social Workers and the California Hospital Association, petitioned for rehearing.

On rehearing of the case, known as Tarasoff II,* the Supreme Court of California significantly modified its earlier opinion. In Tarasoff I the cause of action was somehow anchored in the prior wrongful conduct of the defendant therapist, which then triggered off a positive duty to warn. In Tarasoff II, Judge Tobriner, who read the majority decision, declared that a therapist who, in the course of a professional relationship with a patient, becomes aware that the patient either poses, or may pose, a danger to a third party has a broad positive duty to exercise reasonable care to protect the foreseeable victim.

This broad duty to protect a third party is independent of any earlier conduct by the therapist. Nevertheless the duty to protect incorporates within it a duty to warn, even if giving such warning may entail a breach of the medical duty of confidentiality:

If the exercise of reasonable care to protect the threatened victim requires the therapist to warn the endangered party or those who can reasonably be expected to notify him, we see no sufficient societal interest that would protect and justify the concealment.*

Therefore, in the exercise of a duty to protect a third party, the therapist, in certain American jurisdictions, may have to act in breach of the duty of professional confidentiality because, according to Judge Tobriner:

The public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which the disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins.*
The Supreme Court held that the importance of ensuring the confidentiality of "psychotherapeutic communication" between the patient and the doctor is outweighed by the public interest in protection of endangered persons from violent attack.

The principle that a therapist has a positive duty to exercise reasonable care to protect the foreseeable victim who is not his patient, if necessary through breach of professional secrecy, has come to be known as the Tarasoff II principle. Thus, in those American jurisdictions that have adopted the Tarasoff II principle, a therapist is placed under a positive duty to disclose.

The rule in respect to professional secrecy contained in the American Medical Association's *Principles of Medical Ethics* accommodates the Tarasoff II principle. It states:

A physician may not reveal the confidences entrusted to him in the course of medical attendance . . . unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or the community.\(^1\)

In a number of American jurisdictions, this duty to protect an endangered third party, who originally had to be an identified and a specifically foreseeable person,\(^2\) has been extended to include protection of any foreseeable victim.\(^3\) On the other hand, since Tarasoff II there have been common-law decisions in several American states that have refused to follow the principle of medical duty to warn and protect.\(^4\) Legal developments following the Tarasoff judgment in the United States have been well documented and analyzed in a number of studies by such scholars as Professor Ralph Slovenko and Professor Alan Felthous.\(^5\)
Could Tarasoff happen in Australia?

The set of facts that gave rise to the Tarasoff case certainly could happen in Australia; however, the judicial outcome of any litigation consequential upon such a case would probably be quite different. A number of ethical and jurisprudential reasons make it unlikely that in Australia a therapist placed in the position of Dr. Moore would be held liable for the "failure to protect" a third party.

Medical ethics

The ethical professional duty of medical confidentiality can be traced to the Oath of Hippocrates, the penultimate clause of which states:

What I 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 one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.¹⁷

This original provision imposed upon the physician an obligation to keep confidential all that he observed or became aware of during treatment, and also commanded the doctor not to divulge any information gathered outside of his medical activity that related to his professional relationship with the patient.

The Australian Medical Association’s Code of Ethics¹⁷ contains an amended version of the Declaration of Geneva, which is a modern restatement of the Oath of Hippocrates. The Hippocratic principle of the doctor’s duty of confidentiality is expressed in the following terms by the Declaration of Geneva:

I will respect the secrets which are confided in me, even after the patient has died.¹⁸

The Declaration of Geneva thus preserves the patient’s right to confidentiality and extends it to survive beyond the individual’s death.
The broad ethical notion of medical duty of confidentiality also underlies the position statement and guidelines contained in the Australian Medical Association's Code of Ethics, which states that:

The basis of the relationship between a doctor and his patient is that of absolute confidence and mutual respect. The patient expects his doctor not only to exercise professional skill but also to observe secrecy with respect to the information he acquires as a result of his examination and treatment of the patient.¹⁹

As set out in the guidelines to the Code of Ethics, the relevant principles state that within the context of the doctor–patient relationship it is the practitioner's obligation to observe strictly the rule of professional secrecy by refraining from disclosing voluntarily without the consent of the patient (save with statutory sanction) to any third party information which he has learnt in his professional relationship with the patient.²⁰

The position statement of the Australian Medical Association's Code of Ethics does recognize that "complications of modern life" may give rise to circumstances that will necessitate modification of the strict principle of confidentiality. Presumably, the "complications" refer to those occasions in which the medical practitioner finds himself in a position where the duty of confidentiality to his patient may be in conflict with his civic obligations to the general public.

The guidelines contained in the Australian Medical Association's Code of Ethics in respect to professional confidence focus upon only one situation of possible conflict of duties: namely, where the medical practitioner may feel that the information provided by his patient in the course of a professional consultation should be disclosed to the patient's spouse, yet the patient withholds consent to such disclosure.
The Code of Ethics guidelines on the doctor’s conduct when faced with a recalcitrant patient are as follows:

The principle of professional secrecy still applies as between husband and wife, but there are times when consent if not actually given by a spouse could be reasonably inferred. The decision whether to divulge the information to the other spouse, when consent has not been obtained, would be a matter of discretion of the attending practitioner, which he must exercise with the greatest care and for which he must accept full responsibility at all times. He must adopt a line of conduct that will benefit the patient and protect the patient’s interest. Moreover, if he does anything which damages the patient’s interest he renders himself liable to an action at law.21

Thus, in respect to medical confidentiality in marital relationships, it is the protection of the patient’s interest that is paramount and must take precedence over any third party’s welfare, even if that third party is a spouse and even where nondisclosure may seriously threaten that person’s welfare.

Further, the position statement makes it clear that any doctor who breaches the strict rule of professional secrecy and, without statutory authorization or the patient’s consent, discloses confidential information, either because of his concern for the public good or for the welfare of a particular third party, will do so at his own professional and legal peril.

The 1989 Royal Australian and New Zealand College of Psychiatrists’ Position Statement on Confidentiality of Psychiatric Information22 leave College members to decide for themselves whether they should uphold or breach their professional duty of confidentiality in a situation where they are faced with a patient who poses or may pose a danger to a third party or to the community. According to the R.A.N.Z.C.P. position statement,

[i]t remains a matter of psychiatrists’ discretion to breach confidentiality when they judge that there is a major and acute danger to the community or an individual.23
There are notable differences between the American and the Australian codes of medical ethics. Section 9 of the Principles of Medical Ethics of the American Medical Association allows the physician to reveal privileged information if “it becomes necessary [to do so] in order to protect the welfare of the individual or the community.”

The wording of the above provision implies that the doctor has an inherent duty to protect the welfare of third-party individuals and the community as a whole. However, the code does not specify when and at what level of danger the breach of duty of confidentiality towards a patient will be justified by the doctor’s need to protect others. The judgment in Tarasoff II merely specifies the legal circumstances in which the already existing ethical duty to protect others will override the doctor’s duty to keep silent.

The Australian codes of ethics, apart from placing much stronger emphasis on the negative duty of medical confidentiality than does the American code, explicitly state that the paramount duty of a medical practitioner is to protect the interest of the patient.

Moreover, section 9 of the Principles of Medical Ethics of the American Medical Association gives a general imprimatur for the breach of duty of medical confidentiality when “it becomes necessary” on the grounds of an implied duty towards a third party. The R.A.N.Z.C.P. Position Statement particularizes the issue of disclosure by focusing upon the individual judgment of the treating psychiatrist in each case while at the same time prescribing strict criteria for such disclosure—before a psychiatrist can make a decision to breach the patient’s confidentiality, there has to exist “a major and acute danger to the community or an individual.”
The duty of professional confidentiality and statute law in Australia

The patient whose right to confidentiality has been infringed may bring disciplinary proceedings against the doctor for professional misconduct or for infamous conduct in a professional respect.²⁶

The courts, as well as statutory tribunals such as the medical boards²⁷ and the medical tribunals²⁸ that govern the medical profession, have regard to ethical codes and standards recommended by the Australian Medical Association and the specialist colleges when they are asked to determine what constitutes acceptable conduct of a medical practitioner in relation to the duty of confidentiality.

Where the medical board finds that a practitioner has been guilty of infamous conduct in a professional respect, under Victorian legislation it must remove the practitioner’s name from the register.²⁹

In New South Wales, the medical tribunal investigating a complaint in respect of breach of duty of confidentiality may use either the statutory³⁰ or the common law³¹ definition of “professional misconduct.” Depending on the gravity of his misconduct, a doctor who is found liable for “professional misconduct” faces reprimand, restrictions may be placed upon his practice, or his registration may be suspended.

While mere disclosure to a third party of confidential information that has been obtained in the course of professional practice would generally come within the ambit of “professional misconduct,” releasing professional secrets for monetary gain or mischief by a medical practitioner would constitute the more serious statutory offense of “infamous conduct.”

The cases of Dr. A³² and Childs v. Walton³³ are illustrative of the seriousness with which the medical boards approach the breach of medical confidentiality.
During the course of Mr. B's treatment, Dr. A held a joint consultation with him and his wife. With the permission of Mr. B, he disclosed to the wife the diagnosis of her husband's condition—namely, that Mr. B was "paranoid bordering on schizophrenic." When in 1986 Mrs. B engaged a solicitor to act for her in custody proceedings, she swore an affidavit in which she repeated the diagnosis revealed to her by Dr. A. The solicitor then asked for and received from Dr. A a report confirming the diagnosis. In 1987 Mr. B made a formal complaint to the medical board, on the grounds that by confirming the diagnosis in the report to the solicitor, Dr. A released confidential information about Mr. B.'s condition without his consent. The board found Dr. A guilty of professional misconduct and issued a reprimand.

In the 1990 case of Childs v. Walton, a psychiatrist was removed from the medical register for, inter alia, breaches of professional confidentiality through disclosure to a former patient and lover of the identity and details concerning the problems and treatment of four patients.

The protection of patients' rights to confidentiality has received special attention from all state parliaments, and in particular from the Victorian Parliament, where in the last three years the duty of confidentiality, and punitive measures for its breach, have been included in virtually all legislation relevant to the provision of health care.  

Apart from statutory sanctions, in Australia breach of the patient's confidence may render the doctor open to a claim for damages by the patient at common law.

Common law has imposed a general equitable duty of secrecy upon many people, including medical practitioners. The High Court of Australia has accepted that relief may be granted in equity against an actual or threatened abuse of confidential information that does not involve any tort or any breach of
some express or implied contractual provision or some wider fiduciary duty.\textsuperscript{35}

The equitable duty of confidentiality has been imposed upon doctors not merely because of their role as health providers, but because of the belief that at the basis of a therapeutic relationship is the trust that the patient reposes in his physician. This trust encompasses the principle that, in general, any information imparted by the patient to the physician will not be revealed without the patient’s consent.

Sir Nicholas Browne-Wilkinson, in the case of \textit{Stephens v. Avery \& Others},\textsuperscript{36} expressed the equitable source of the duty of confidentiality in the following terms:

Although the relationship between the parties is often important in cases where it is said there is an implied as opposed to express obligation of confidence, the relationship between the parties is not the determining factor. It is the acceptance of the information on the basis that it will be kept secret that affects the conscience of the recipient of the information.\textsuperscript{37}

Thus, the equitable duty of confidentiality is based upon the ethical principle that where a person reposes information in another in confidence, his conduct raises a reciprocal moral duty on the part of the recipient to observe confidentiality.

The patient, who is the beneficiary of the duty, may elect either to give his consent to the disclosure or to restrain the doctor from disclosing confidential information. In the latter case, the court in its equitable jurisdiction may intervene to enforce the patient’s right to confidentiality.\textsuperscript{38}

There are, however, limits imposed on the duty of medical confidentiality.

The duty of confidentiality may be overridden by statute. Thus, under section 35 (IX-XI) of the Queensland Medical Act, 1939–1988, medical practitioners are statutorily com-
peled to divulge certain information to the police when there is a suspicion of crime. Failure to do so may render the doctor liable for misconduct in a professional respect.

In all Australian states, medical practitioners are required by legislation to report certain infectious diseases and cancer. Notice must be given in respect to patients who are drug dependent and whenever a motorist fails to give a blood sample under the relevant Road Safety Acts.

Even at common law, the scope of the common-law duty of confidentiality does not extend to coronial and criminal proceedings, doctors in all Australian states are obliged to divulge information about their patients in criminal cases.39

In the 1988 Spycatcher case,40 Lord Goff of Chieveley formulated three common-law principles that may limit the scope of the legal-equitable duty of confidentiality. The first principle refers to the fact that the duty of confidentiality applies only to that information which has not entered the public domain. The second limiting principle excludes trivial and useless information from the scope of the duty.

The third principle that may limit, or even nullify, the duty of confidentiality is based upon public interest. Lord Goff of Chieveley defined the third principle in the following way:

The third limiting principle is of far greater importance. It is that, although the basis of the law’s protection of confidence is that there is a public interest that confidences should be preserved and protected by law, nevertheless that public interest may be outweighed by some other countervailing public interest which favors disclosure. This limitation may apply . . . to all types of confidential information. It is this limiting principle which may require a court to carry out a balancing operation, weighing the public interest in maintaining confidence against a countervailing public interest favouring disclosure.41
The equitable duty of professional confidence and the principles limiting scope of this duty, together with guidelines of ethical conduct in respect to professional secrecy set out by the British Medical Association, were adopted by the English Court of Appeal in the case of W. v. Egdell as applying to the medical profession at common law.

In this case, the patient, W., shot dead five people and seriously wounded two others in 1974. He pleaded guilty to manslaughter on the grounds of diminished responsibility. The plea was accepted, because he was diagnosed as suffering from paranoid schizophrenia. As a result, W. was detained without the limit of time in a secure hospital. In 1986 W. was recommended for transfer from a secure hospital to a secure regional unit with a view to eventual release. The home secretary refused consent to the transfer, so W. applied to the mental health review tribunal; in support of his application he sought a report, through his solicitors, from an independent consultant psychiatrist, Dr. Egdell, the subsequent defendant.

Dr. Egdell submitted to W.'s solicitors a detailed psychiatric report that did not favor the transfer, because his professional opinion pointed towards the diagnosis that W. suffered from paranoid psychosis and psychopathic personality rather than from paranoid schizophrenia.

When it became clear to Dr. Egdell that the solicitors did not intend to place his report before the tribunal (or anyone else), he telephoned the medical director of the secure hospital to tell him about his concern in respect of differing diagnosis. He eventually supplied a copy of the report to the medical director. One of the resident doctors at the secure hospital informed W.'s solicitors about Dr. Egdell's actions, and W. sued Dr. Egdell for breach of confidentiality.
The case was originally heard in 1988 by Justice Scott in the Chancery Division, and later on by the Court of Appeal in 1989.\textsuperscript{46}

The approach of the English courts had been to accept that the duty of medical confidentiality is the normative principle of public interest that applies to all categories of patients. The doctor’s breach of this duty on the grounds of a conflicting public interest should not be presumed but must be justified by the circumstances of each individual case.

In respect to \textit{W. v. Egdel} the Court of Appeal decided that in this particular case, public interest in disclosure overrode the competing public interest that there should be confidentiality between doctor and patient.

The \textit{Egdel} decision was quoted in the case of \textit{Peter Michael Anthony Crozier},\textsuperscript{47} where the accused, Crozier, pleaded guilty to an attempted murder.\textsuperscript{48} Crozier’s counsel, appearing at the sentencing hearing, was unaware that his own instructing solicitors had commissioned a medical report and therefore did not mention it to the sentencing judge. Dr. McDonald, who prepared the report, was of the opinion that Crozier was suffering from a mental illness of a psychopathic nature that warranted detention in a special hospital. Dr. McDonald arrived in court in time to hear the judge pass a sentence of nine years of imprisonment. Knowing that Dr. Wright, the psychiatrist on whose report the judge had relied,\textsuperscript{49} had changed his opinion and now agreed with his view, Dr. McDonald approached the counsel for the Crown and disclosed to him the contents of the report. The Crown applied for a variation of sentence to a hospital order coupled with restriction under Mental Health Act 1983, which was granted.

Appealing against the indeterminate hospital order, Crozier also put in issue the propriety of the doctor’s action in revealing privileged information, claiming that he would not have agreed to the disclosure. In dismissing the appeal, the Court
of Appeal noted that Dr. McDonald was in much the same position as Dr. Egdell, whose duty of confidentiality did not prevent him from taking . . . steps to communicate the grounds for his concern to the responsible authorities, if he became aware of information which led him to fear that decisions of a body charged with deciding whether a patient could safely be released would be made on the basis of inadequate information.  

In the present case, the strong public interest in the disclosure of Dr. McDonald's view—that Crozier's psychopathic disorder constituted a continuing danger to the public—overrode his medical duty of confidentiality to an individual patient.  

It should also be noted that in both of the English cases the consultant psychiatrists did not see the respective plaintiffs for therapeutic purposes. Both W. and Crozier were seen for medico-legal assessment on behalf of the referring solicitors. The issue of duty of medical confidentiality sensu stricto did not arise, since the very purpose of these consultations was disclosure, though admittedly the informants had the right to decide who should receive data contained in the reports. 

The information disclosed by the consultant psychiatrists to "the responsible authorities" did not contain any material that was secret and revealed by virtue of confidential relationship. Rather, the disclosure became controversial because the respective diagnoses about the plaintiffs' current mental condition were seen as adverse to the plaintiffs' social interests. These factors were taken into account by the judiciary when they decided that in the circumstances, the breach of confidentiality was justified. 

Even so, the English approach renders the doctor who divulges confidential information without the patient's consent or statutory authorization prima facie in breach of the duty of confidentiality, having to face the concomitant professional and legal consequences of such breach. The doctor
may plead justification of the disclosure in the public interest, but it will be up to the court to balance the interest to be served by nondisclosure against the interest served by disclosure. Thus, in England the doctor who without consent or statutory authorization breaches his duty of confidentiality always risks the threat of litigation at common law.

The Australian position

Similarly, in Australia, in cases where the practitioner becomes aware that the patient contemplates commission of a crime or an antisocial act, the doctor will act at his own peril if, by warning others, he breaks the duty of professional secrecy.

A duty to perform an act of care may arise where the doctor has a statutory right and power to control the patient who may pose danger to the plaintiff. In a medical context, such a relationship would arise only in a situation where the patient is in the custodial care and control of a psychiatric hospital through involuntary admission. In cases where such a special relationship between the doctor and his patient exists, the doctor may be required to take positive action to ensure that the patient under his custody and control does not cause injury to others. 49

However, it is doubtful that even in a custodial setting the duty of positive action would extend to the doctor having to issue warnings to protect third parties in breach of his duty of confidentiality to the patient. This is because such common-law-imposed obligation would be contrary to the statutory provisions that impose penal sanctions for breach of professional secrecy.

For instance, the Mental Health (General Amendment) Act (Vic.) 1990, which governs state-run mental health institutions, provides for a penalty of 50 penalty points for breach
of confidentiality by “psychiatric service providers.” The Act permits communication of confidential information
to the next of kin or near relative of the patient in accordance with the recognized customs of medical practice. The “psychiatric service provider” may communicate to the family or the next of kin any dangerous proclivities of the patient, but he is not legally bound to warn them, unless he thinks that to do so would be in the best interest of the patient.

While the Act, under the rule of *expressio unius est exclusio alterius*, does not allow for a disclosure of privileged information to third parties who are not within the ambit of “the next of kin or near relatives,” it does provide for a “public interest” exception, which states that confidential information may be given
to a person to whom in the opinion of the Minister it is in the public interest that the information be given.

The Act does not define the character or status of “a person” who can receive the information; however, the term presumably will encompass a threatened third party. Yet, even then, a medical practitioner working within the ambit of the state-controlled psychiatric services must not breach his duty of professional secrecy by acting at his own discretion and warning a third party of the danger posed by a patient; he should first obtain a “clearance” to do so from the Minister.

The requirement of custodial care will probably exclude from the ambit of the duty of positive action doctors who see private patients in a noncustodial setting. Such duty, though, may arise either from statute or from the defendant’s own antecedent conduct, as where the defendant doctor’s conduct has created the risk of injury to the plaintiff or has increased such risk.
A treating practitioner may come within the ambit of the duty if the plaintiff can show that the former had encouraged the aggressive tendencies of his patient either verbally, through medication, or through failure to hospitalize a patient in need of treatment in restricted surroundings. In the latter case, it is possible that an Australian court may regard the conduct of a doctor who did not arrange either for voluntary or for involuntary detention of the patient as a factor that has increased—though not created—a risk of injury to the plaintiff.

It is debatable whether Poddar, at the time when Dr. Moore attempted to arrange for his civil commitment, would come within the ambit of the criteria set out for involuntary admission and detention under Under s. 8(1) of the Victorian Mental Health Act, which provides that a doctor may involuntarily commit a person only if:

(a) the person appears to be mentally ill;

(b) the person’s mental illness requires immediate treatment or care and that treatment or care can be obtained by admission to and detention in a psychiatric inpatient service;

(c) the person should be admitted and detained as an involuntary patient for that person’s health and safety or for the protection of members of the public;

(d) the person has refused or is unable to consent to the necessary treatment for the mental illness; and

(e) the person cannot receive adequate treatment or care for the mental illness in a manner less restrictive of that person’s freedom of decision and action.
Furthermore, s. 8(2)(1) states that a person is not considered to be mentally ill by reason only that "he has an antisocial personality."

The above criteria are cumulative—all five need to be fulfilled before a valid commitment can be executed. Since the criteria do not rely on the safety of the patient or the public, but focus on those patients who need treatment in restricted surroundings, Poddar would not come within them. Consequently, in Australia a therapist's nonhospitalization of a person of Poddar's state of mind could not be regarded as conduct giving rise to a positive duty of care towards a third party, even if that party may face an increased risk of injury as a result.

The duty of positive action may also arise in circumstances where the plaintiff is a patient of the medical practitioner and as such specifically relies upon the defendant-doctor to act to prevent an injury to him, and where the doctor can fulfill the plaintiff's expectations without breaking the law.

However, it is unlikely that a positive duty of care to warn and protect a third party would be imposed on a doctor whose patient has expressed threats directed towards a third person who is not a patient of the medical practitioner.

In distinction to misfeasance, which is a positive wrongful conduct actionable in negligence, the medical practitioner's decision not to volunteer privileged information and warn a threatened third party would be regarded as an instance of nonfeasance.35

Australian law holds that in general, conduct amounting to nonfeasance will fall beyond the scope of the legally imposed duty of care, unless the plaintiff can prove the existence of the special requirement of proximity as between himself and the defendant. The principle that there is no general duty to
warn is similar to that expressed in the Restatement and goes back to 1867, when Willes J. declared that

[no] action will lie against a spiteful man who, seeing another running into a position of danger, merely omits to warn him.\(^6\)

This principle was reaffirmed in 1985 by the High Court of Australia in the case of Council of the Shire of Sutherland v. Heyman,\(^5\) where the Court stated that the nonperformance of a positive act will not be regarded as negligent in Australian law unless the plaintiff can show that the defendant was under a \textit{positive duty} to act in order to prevent the reasonably foreseeable injury that ensued. According to Mr. Justice Dean:

The common law imposes no prima facie general duty to rescue, safeguard from or warn another from or of a reasonably foreseeable loss or injury or to take reasonable care to ensure that another does not sustain such loss or injury.\(^3\)

In the \textit{Heyman} case, the majority on the High Court of Australia\(^9\) adopted the principle that in cases of nonfeasance the duty of care will be deemed to exist only in cases where the test of reasonable foreseeability is supplemented by the special proximity requirement:

\ldots reasonable foreseeability of a likelihood that such loss or injury will be sustained in the absence of any positive action to avoid it does not of itself suffice to establish such proximity of relationship as will give rise to a prima facie duty on one party to take reasonable care to secure avoidance of a reasonably foreseeable but independently created risk of injury to the other.\(^6\)

The special requirement of proximity controls and qualifies the \textit{Donoghue v. Stevenson}\(^6\) test of whether the defendant could have reasonably foreseen that a real risk of injury to the plaintiff might result from his conduct.

The express function of the proximity requirement is to limit the scope of the duty of care either by negating the duty of
care altogether on the grounds of public policy, or by limiting the class of people to whom the duty of care applies. Thus, in Australia it is the “independent and necessary requirement” of proximity rather than reasonable foreseeability that now controls those categories of cases in which the common law has to decide whether to admit the existence of the duty of care.

The test of proximity is a question of law. The plaintiff who has been harmed because of the absence of warning about the danger posed by the treating practitioner’s patient must establish—the burden of proof is upon him or her—the presence of the special requirement of proximity before the court will admit duty of care to exist. The extended concept of proximity involves the notion of nearness, such as physical proximity, circumstantial proximity, causal proximity, or proximity based upon policy considerations.

Physical proximity includes space and time; circumstantial proximity, inter alia, includes professional doctor/patient relationships as well as relationships where it can be shown that the defendant assumed responsibility to take care to prevent injury to the plaintiff in circumstances where the plaintiff had reasonably relied upon care being taken by the defendant because the latter had induced or encouraged such reliance and was, or should have been, aware of it. The concept of causal proximity emphasizes the closeness and directness of the causal connection or relationship between the particular wrongful conduct and the injury thereby sustained. Proximity based upon policy considerations involves an examination by the court of the actual relationship between the parties and the factors within this relationship that may affect the normative content of the duty of care.

The Tarasoff set of facts disclosed no contact between Tatiana and the defendant therapist; therefore the element of physical or temporal proximity could not be established. Since Tatiana was not a patient of Dr. Moore nor in any way
involved with Poddar’s treatment, there was no circumstantial proximity between her and Dr. Moore. Although aware of the existence of a person named Tatiana Tarasoff, the defendant therapist had no association with her; thus he could neither encourage nor induce her to rely upon his advice, information, prediction or warning in respect to Poddar.

In order to succeed in establishing causal proximity, Tatiana would have had to show that the defendant therapist’s conduct was such as to positively contribute to her reliance and that she reasonably relied upon it to her detriment. In Australia, Tatiana could not have relied on the ethical codes as a source of the therapist’s duty to protect her through disclosure, because at the time of his termination of treatment, Poddar posed a “major” but not an “acute” danger to Tatiana, who was holidaying in Brazil. Moreover, even if the risk of injury to Tatiana had been both “major and acute,” it is doubtful that the court would infer reasonable reliance from the fact that since the ethical codes of the profession permit, though not encourage, privileged disclosure in certain circumstances, the particular therapist would volunteer to breach his duty of confidentiality to his patient in order to protect the welfare of a third party.

Finally, proximity based upon policy considerations would need to have been pleaded. The English cases of W. v. Egdell and Crozier, in which an unauthorized disclosure was found to be justified, involved medical practitioners who disclosed the content of confidential reports to the authorities responsible for the protection of the general public. Thus the balance of interests involved in the content of the duty of care was not as between two individuals, but as between the duty that the doctor owes to an individual—though grounded in the public interest in maintaining trust between the doctor and the patient—and the duty that the doctor owes to society through its responsible authorities to maintain public safety. In a Tarasoff-like case, the court would need to consider two competing individual interests.
In view of the above considerations, it is unlikely that the Tarasoff II principle of positive duty to warn and protect a third party would be accepted in Australia. At most, in Australian law a psychiatrist might have a discretion to breach his professional duty of confidentiality, having regard to all the issues involved in the situation confronting him.

Notes


3. *Restatement (Second) of Torts*, s. 315.


5. Although not all therapists are medical graduates, I will refer to therapists, psychiatrists, doctors and medical practitioners interchangeably, because the issues discussed pertain to each and all of these professionals.

6. The effective cause of the abandonment of Poddar’s civil commitment was the campus police; however, it is clear from the judgment that Dr. Moore was seen as having failed to ensure that his request was carried through.

7. The Supreme Court did not differentiate between the failure to hospitalize, which might have constituted an act of misfeasance within positive conduct of a therapeutic relationship of the doctor and the patient, and a separate issue of nonfeasance, which arose between the doctor and a third party. The issue of misfeasance and nonfeasance will be discussed at greater length below.


11. *Principles of Medical Ethics of the American Medical Association*, s. 9.


18. Idem, para. 3.1.5.


20. Idem, para. 6.2.2.

21. Idem, para. 6.2.3.


23. Idem, para. 3.5.

24. Principles of Medical Ethics of the American Medical Association, s. 9.

25. Position Statement, para. 3.5.

26. It should be noted that the investigative and disciplinary powers granted to medical boards and tribunals are designed to protect the public. They are not punitive.

Victoria: Medical Practitioners Act 1970, s. 16,17 and s. 17B; N.S.W.: Medical Practitioners Act 1938, s. 27, s. 28 (1)(d) and (f); Qld.: Medical Act 1939, s. 35; S.A.: Medical Practitioners Act 1983, s. 5; W.A.: Medical Act 1984, s. 13(1); Tas.: Medical Act 1959.
27. Victoria, Tasmania, Western Australia and Australian Capital Territory.

28. New South Wales, Queensland, South Australia and Northern Territory.


30. *Medical Practitioners Act* 1938, s. 27 (1) (a).

31. The common law test as propounded in *Qiway v. Brown* [1984] 1 N.S.W.L.R. 100, confirmed and approved in *Pillai v. Messiter (No. 2)* (1989) 16 N.S.W.L.R. 197, in addition to the requirement that the doctor under investigation must be shown to have lacked adequate knowledge, skill or care in his/her practice of medicine, also places an emphasis on the conduct in question having to "attract strong reprobation" of the medical practitioner's brethren of good repute and competence.


34. The preamble to the *Health Services (Conciliation & Review) Act (Vic.)* 1987 emphasizes the patient's right to "the confidentiality of personal health records." Section 141 of the *Health Services Act (Vic.)* 1988 prohibits staff from communicating or divulging information concerning patients.

The *Health Act (Vic.)* 1958 has imposed a general duty of confidentiality upon all medical practitioners. Section 162H (1) of the same Act has imposed a penalty of 20 penalty units upon the members of and persons associated with the Consultative Council on Obstetrics and Paediatric Mortality and Morbidity who divulge confidential information.


37. *Idem*, p. 482.

38. *Idem*, p. 482.

39. In the case of *Brown v. Brookes & Ors.*, Supreme Court of N.S.W., August 1988 (unreported), the patient, who had been charged with sexual assault upon his daughters, sought an injunction in the Supreme Court of N.S.W. to prevent the hospital from divulging certain information he had given to the nurse in the hospital psychiatric unit.

In his refusal to grant the injunction, Mr. Justice McLelland stated that where serious criminal offenses are involved, the degree of public interest in maintaining the duty of medical confidentiality in respect to information relevant to the criminal investigation and prosecution is not sufficient to justify judicial enforcement of such obligation, because it "would involve an impermissible obstruction of the due administration of the criminal law."


43. The leave to appeal by the defendant to the House of Lords from the decision of the Court of Appeal has been refused.


45. Angered by a dispute over a trust fund, Crozier tried to run his car over his sister. He then broke down her front door and attacked her with an axe. A passer-by intervened and prevented the attack from going further.

46. Dr. Wright originally reported that although Crozier was sane and not within the scope of the Mental Health Act 1983, he was dangerous to other members of his family.

47. *Crozier*, op. cit., p. 207.

48. The Court of Appeal added that even if Dr. McDonald were found to be in breach of confidence, once the medical evidence had been drawn to the attention of the court, the judge could not ignore it, but had to act upon the report as he thought right in the public interest.


50. *Mental Health (General Amendment) Act (Vic.)* 1990, s. 120A.
51. Mental Health (General Amendment) Act (Vic.) 1990, s. 120A (3) (c) (ii).

52. Mental Health (General Amendment) Act (Vic.) 1990, s. 120A (3) (c) (ii).

53. Mental Health Act (Vic.) 1986. Although the discussion is being confined to the Victorian legislation, essentially similar criteria for involuntary admission operate in other states of Australia.

54. Mental illness is not defined in the Act. However, the Mental Health Review Board has defined "mental illness" in the following way: "A person appears to be suffering from a mental illness if he/she has recently exhibited symptoms which indicate a disturbance of mental functioning which constitutes an identifiable syndrome or if it not be possible to ascribe the symptoms of such disturbance of mental functioning to a classifiable syndrome, they are symptoms of disturbance of thought, mood, volition, perception, orientation or memory which are present to such a degree as to be considered pathological." In the appeal of Garry Webb (also known as Garry David), a security patient at Aradale Hospital. Heard on May 9, 1990 (unreported).

55. In the circumstances where a duty of care can be shown to exist, the failure to warn by making a statement when making of such statement would have avoided the injury will be classified as a negligent misstatement: Hawkins v. Clayton [1988] Aust. Torts Reports 80-163.


58. Council of the Shire of Sutherland v. Heyman, idem, pp. 68, 318. The High Court has employed the test of proximity to establish the existence of duty of care in the case of nonfeasance by a firm of solicitors towards an executor and a beneficiary under the will: Hawkins v. Clayton, op. cit.

59. The proximity test is not without its critics. At the High Court, its most notable and consistent critic has been Mr. Justice Brennan, via his dissenting judgment in: Gala & Ors. v. Preston [1991] Aust. Torts Reports 80-105.


63. Gala & Ors. v. Preston [1991], op. cit.

64. In Australia, under the survival of actions legislation, it must be established that the defendant’s conduct was wrongful; that it caused the death and that but for the death, the deceased could have successfully brought an action in relation to the injury.


66. Position Statement, para. 3.5.

67. The High Court has yet to identify the specific considerations that will either establish or negate proximity on the policy basis.