"Mr Cruel" and the Medical Duty of Confidentiality*

The author explores legal and ethical ramifications arising from a letter sent by the Medical Board and the Victoria Police to Victorian doctors requesting them to divulge details of any patient they suspected might have committed a series of violent attacks on young girls. She examines the ethical obligations of medical practitioners to disclose information obtained under confidential auspices pursuant to the 1992 AMA and RANZCP Codes. The author also assesses the legal and practical position of doctors who comply with requests such as those sent to them in relation to "Mr Cruel".

DANUTA MENDELSON
MA, PhD, LLB (Hons)
School of Law, Deakin University

In April 1992, the President of the Medical Board in Victoria, the Detective Inspector of Spectrum Task Force of the Victoria Police, and two forensic physicians jointly drafted a confidential letter addressed to every registered medical practitioner in Victoria, appealing for assistance in the investigations by the Spectrum Task Force of a series of offences attributed to "Mr Cruel". "Mr Cruel" was believed to be responsible for the abduction and sexual assault of a number of young girls in Melbourne and the murder of Karmein Chan. The letter encouraged doctors to disclose their patient's identity if they suspected that he might be "Mr Cruel" on the basis of certain characteristics apparently attributable to this person. The appeal to disclose confidential information contained the following statement:

> "If you believe you could help identify this offender you may consider your duty to the community outweighs your duty to the patient. This is a judgment that will not be easily made. . . . It is generally held that disclosure in the public interest is justified when failure to disclose exposes the public to a significant risk of death or serious harm. The Medical Board of Victoria affirms that this principle appears to apply in the present circumstances."[1]

This article will discuss the ethical duties, professional responsibilities and legal obligations of a medical practitioner in situations where the doctor's professional and ethical duties to the patient are perceived as being in conflict with his or her civic duty to society at large.

If the doctor is unable to persuade the patient who he or she suspects is "Mr Cruel" to either give himself up to the police, or to waive his right to medical confidentiality so that the authorities can be informed, the medical practitioner will have to decide whether or not to divulge the information over the patient's refusal of consent to such disclosure.

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[1] Confidential letter, "The Spectrum Taskforce and 'Mr Cruel' ", 30 April 1992. The letter was discussed on radio and television news programmes in early May 1992.

Before the question of what the medical practitioner should do can be answered, it is necessary to examine some fundamental concepts which govern the duty of medical confidentiality in the light of professional ethics, common law and statutes.

Ethical position

It is appropriate to start at the beginning, that is with the Hippocratic Oath.[2] The Hippocratic Oath was written around 460 BCE, and is the first known code of ethics and professional etiquette pertaining specifically to the medical profession. The penultimate clause of the Oath concerns the duty of medical professional confidentiality. It 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."[3]

This provision of the Hippocratic Oath imposes upon the physician an obligation to keep private all that he or she observes or becomes aware of during the course of treatment, and also commands the doctor not to divulge any information gathered outside of medical activity and which relates to the professional relationship with the patient. In today's parlance, the Hippocratic injunction of secrecy recognises that at the basis of the therapeutic doctor-patient relationship is mutual respect. This involves two reciprocal obligations—an obligation on the part of the patient to disclose all factors which may be relevant to the diagnosis, prognosis and treatment of his or her complaint or condition, and a responsibility on the part of the medical practitioner to exercise professional skill, and to observe secrecy with respect to any information acquired as a result of the examination and treatment of the patient.[4] The law regards the interest in maintaining professional duties of medical confidence as an important public interest based upon the principle that it is in the interest of public health to encourage patients to disclose personal information truthfully without fear of embarrassment, stigma or incrimination[5] that such disclosure may generate.[6]

It is also arguable that a fully rounded legal principle of a patient's autonomy and self-determination must be accompanied by an ethical and philosophical concept of personal privacy grounded in the ownership and control of information supplied by, or appertaining to, the patient, and guarded by the medical duty of confidentiality.[7] A number of European countries, including France and Belgium, accord therapeutic patient-doctor relationships an absolute privilege of confidentiality.

The year 1992 was memorable in many respects; however, in the annals of the Australian medical profession, it will be remembered as *the year of the Ethical Code*. In July and August 1992 respectively, the Australian Medical Association (AMA) and the Royal Australian and New Zealand College of Psychiatrists (RANZCP) each published a *Code of Ethics*, and the Royal Australasian College of Physicians issued a handsomely produced publication called *Ethics: A Manual for Consultant Physicians*.

[2] The Hippocratic Oath forms part of the Corpus Hippocraticum which was written between 460 and 300 BCE.

[3] L Edelstein, *Ancient Medicine* (Johns Hopkins University Press, Baltimore, 1987), p 6.

[4] Australian Medical Association, *Code of Ethics* (1989 ed), incorporating Decisions of the Federal Assemblies up to and including the 27th Federal Assembly of May 1988, par 6.1.1.

[5] In the sense of providing incriminating evidence.

[6] The public interest principle of medical confidentiality was explained by Rose J in *X v Y* ([1988] 2 All ER 648 at 653) in the following way: "In the long run, preservation of confidentiality is the only way of securing public health; otherwise doctors will be discredited as a source of education, for future individual patients 'will not come forward if doctors are going to squeal on them'. Consequently, confidentiality is vital to secure public as well as private health, for unless those infected come forward they cannot be counselled and self-treatment does not provide the best care." In this case, Rose J granted a permanent injunction restraining a reporter of a national newspaper from publishing any information which would disclose the identity of two medical practitioners who were treated in hospital for AIDS. The reporter obtained the confidential information from an employee of the hospital. *W v Egdell & Ors* [1989] 2 WLR 689; *W v Egdell* [1990] 2 WLR 471 at 488-489.

[7] H Lasser and Z Pickup, "Law, Ethics and Confidentiality" (1990) 17 *Journal of Law and Society* 17-28.

The updated AMA *Code of Ethics* defines the medical practitioner's obligation of confidentiality in the following way:

> "In general, keep in confidence information derived from your patient, or from a colleague regarding your patient, and divulge it only with the patient's permission, except when a court demands."[8]

Thus, under the AMA definition, a medical practitioner who voluntarily divulges identifying information about a patient whom the doctor suspects to be a wanted criminal, will be in breach of the professional code of ethics.

The RANZCP *Code of Ethics*[9] has been formulated as a set of nine annotated principles which draw upon moral philosophy and aim to serve as a guide to good professional conduct.[10] Principle (3) outlines the duty of medical confidentiality in the following way: "Psychiatrists shall hold information about the patient in confidence."[11] This general injunction of confidentiality is qualified in the Annotations which state that medical confidentiality cannot always be absolute, but is subject to the constraints of legal and statutory requirements. According to Annotation (2):

> "a careful balance must be maintained between preserving confidentiality as a fundamental aspect of clinical practice and the need to breach it on rare occasions in order to promote the patient's optimal interests and care, and/or safety or other significant interests of third parties."[12]

The first justification for breach of medical confidentiality provided by Annotation (2) is clear: contemporary good clinical practice demands sharing of otherwise confidential information with other medical practitioners who participate in or assume management of the patient. Likewise, confidential information may be shared with other health-care professionals who are assisting or collaborating in the treatment of the patient, though only to the extent that the treating practitioner deems it absolutely necessary.

The second justification for breach of confidentiality on the grounds of promotion of "safety and/or other significant interests of third parties" is more problematic because its width makes it open to diverse interpretations. If the phrase "safety and/or other significant interests of third parties" is read as including the interest of the community in the apprehension of wrongdoers and the punishment of criminal conduct, the psychiatrist who follows the RANZCP *Code of Ethics*, and who suspects that his or her patient is "Mr Cruel", would need to balance the public interest in preserving the patient's confidentiality against the public interest in apprehending and bringing the offender to trial.

In balancing these conflicting public interests, regard must be paid to the reasons for the medical practitioner's suspicions in respect of the patient's identity. Is the doctor acting merely on coincidental resemblance between the description of "Mr Cruel" contained in the Spectrum Task Force letter or did the patient, who answers to that description, actually confess to being "Mr Cruel"? Even in the case of confession, how can the medical practitioner be certain that the confession is a true rather than a false confession? The issue of false confession is of considerable importance, because it is the role of the

[8] Australian Medical Association, *Code of Ethics* (July 1992).

[9] The Royal Australian and New Zealand College of Psychiatrists, *Code of Ethics* (August 1992).

[10] Ibid, Preamble.

[11] Ibid, pp 7-8.

[12] Ibid, p 7.

law-enforcement agencies and of the courts to investigate and to judge the legal probity of the person's statements. The duty of a medical practitioner is to act in the best interests of his or her patient by professional analysis, in a non-judgmental way, of psychological and/or medical reasons for the patient's statement.[13] In general, medical practitioners should reflect upon their function within society—has the society designated doctors as guardians and defenders of public safety, or is the primary duty and professional responsibility of each medical practitioner to endeavour to cure, to relieve pain and suffering, and to provide comfort, without bias or prejudice, to any member of the community who seeks medical assistance?

Legal position

At common law, the issue of whether and if so, in what circumstances, medical practitioners should disclose confidential information was determined by Lord Mansfield in 1776 in the *Duchess of Kingston's Case.*[14] In that case, the accused, Elizabeth Chudleigh (b 1720?), secretly married a Mr Harvey in 1744. The marriage did not thrive. In 1768, the parties discussed initiating divorce proceedings, but instead of agreeing to the legal dissolution of marriage, Elizabeth successfully sued in the Ecclesiastical Court for jactitation of marriage (a false assertion that one is married to someone to whom one is not, in fact, married).[15] In 1769, having obtained a document stating that the presumption of her marriage to Mr Harvey did not arise, Elizabeth married the Duke of Kingston, one of the wealthiest men in Georgian England. The Duke died in 1773, leaving Elizabeth his vast fortune for the period of her widowhood. One of the Duke's disinherited nephews disputed the terms of the will, alleging that Elizabeth's first marriage was never lawfully dissolved and therefore she was not the late Duke's "wife" in the sense of being a lawful spouse. The nephew's allegation eventually led in 1776 to the trial of the Duchess for bigamy, which was nominally a capital offence.[16] During the trial before the House of Lords, Mr Caesar Hawkins, a surgeon, was called as a witness. He had attended Elizabeth, Mr Harvey and their son some 30 years earlier. When asked by the court whether he knew *from the parties* of any marriage between them, the surgeon answered:

> "I do not know how far anything that has come before me in a confidential trust in my possession should be disclosed, consistent with my professional honour."[17]

Lord Mansfield CJ made the following ruling in respect of Mr Hawkins' inquiry:

> "If a surgeon was voluntarily to reveal these [professional] secrets, to be sure, he would be guilty of a breach of honour and of great indiscretion, but, to give that information in a Court of justice, which by the law of the land he is bound to do, will never be imputed to him as any indiscretion whatever."[18]

Lord Mansfield's ruling meant that, at common law, when questioned by a civil or a criminal court, the medical practitioner has no legal right or privilege to remain silent on the witness stand.[19] New South Wales, South Australia, Western Australia and the Australian Capital Territory have generally adhered to Lord Mansfield's ruling that a

[13] For a contrary view, see N Walker, "Dangerous Mistakes" (1991) 158 *British Journal of Psychiatry* 752-757; H Prins, "How Dangerous Is It that This Man goes Loose!" (1992) 32 *Medicine, Science and Law* 93-94 (Editorial).

[14] *Duchess of Kingston's Case* (1776) 20 State Tr 355. L Melville (ed), *Trial of the Duchess of Kingston* (William Hodge & Co Ltd, Edinburgh and London, 1927).

[15] Elizabeth complained to the Ecclesiastical Court that Mr Harvey improperly and without foundation laid claim to her as his wife, in other words that he did jactitate that she was his wife. In all cases where one party to litigation asserted the existence of marriage and the other denied it, the Ecclesiastical Court pronounced that these two parties were free from any matrimonial contract. However, for the sentence of the Ecclesiastical Court to be binding at common law, the party denying the marriage had to show that there was no foundation to such claim.

[16] Bigamy was a statutory capital offence for common people. Originally, the punishment for women who were found guilty of bigamy was burning; in the 18th century this punishment was commuted to life sentence and transportation or searing of the hand. However, the peers of the realm were not subject to these statutory provisions. Though her marriage to the Duke—and thus her title—was in dispute, in accordance with the principle of English law that a person is innocent until proven guilty, Elizabeth, as a Duchess, was tried before her peers (the House of Lords). She was found guilty of bigamy with the late Duke, on the grounds that she was never validly divorced from Harvey. Yet Elizabeth was still able to plead benefit of peerage, which meant that, despite her guilt, she had to be discharged without any penalty. This was because in 1774 Mr Harvey succeeded to the Earldom of Bristol which made his still lawful wife, Elizabeth, a Countess. Being a Countess saved her from being burnt in the hand.

[17] Melville, op cit n 14, p 244.

[18] Ibid.

[19] Lord Mansfield reposed the privilege of confidentiality in the

criminal as well as civil court can compel a medical practitioner to answer questions in respect of a patient's medical history. The statutory position in other Australian States and Territories, with particular attention to Victorian legislation, will be discussed below.

Statutory position

In Victoria,[20] Tasmania[21] and the Northern Territory,[22] the common law has been modified by statute which established the patient's privilege of medical confidentiality. The evidentiary patient-doctor privilege prohibits disclosure by doctors of any information acquired in attending the patient in "any civil suit or proceeding" without consent of the patient.[23] A patient's evidentiary privilege does not apply to criminal and coronial proceedings,[24] and there are also other statutory limits imposed on the duty of medical confidentiality.[25] In Queensland, under the *Medical Act* 1939 (Qld),[26] medical practitioners are statutorily compelled 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.

Since the statutory provisions of the *Evidence Act* in Victoria, Tasmania and the Northern Territory are directed towards the "physician or surgeon", the evidentiary privilege is exclusive to the doctor-patient relationship and does not extend to any other health-care professionals. In Victoria, however, the duty of confidentiality has been extended to other persons who are employed in, or provide health services in, public or private hospitals, nursing homes or community health centres, by virtue of provisions included in the *Health Services Act* 1988 (Vic).[27] These provisions preclude health-service providers from giving any identifying information, where this information has been acquired by reason of such person being an employee of a public hospital, if the patient could be identified in any way from the information.[28] Similar confidentiality provisions in respect of psychiatric patients have been introduced also into the *Mental Health Act* 1986 (Vic).[29] The *Mental Health Act* provisions prohibit any person who falls within the relevant definition[30] from giving to any other person, whether directly or indirectly, any information from which a patient could be identified.[31] The breach of the statutory provisions of confidentiality under either the *Health Services Act* 1988 (Vic), or under the *Mental Health Act* 1986 (Vic) carries with it a criminal sanction of maximum 50 penalty units, amounting to $5,000.[32]

There are three partial exemptions[33] and nine exceptions to the confidentiality provisions under the *Health Services Act* and the *Mental Health Act*. Included among the exceptions are the waiver of confidentiality through the patient's consent;[34] giving of information required in connection with further treatment of the patient;[35] providing information concerning the condition of a patient in general terms; and communicating information to the patient's next of kin or a near relative "in accordance with the recognised customs of medical practice".[36] Both Acts have retained the exception allowing the disclosure of confidential information to "a court in the course of criminal proceedings".[37] However, the wording of the respective

19 *Continued*
medical practitioner rather than in the patient when he said that "a surgeon has no privilege". However, until modified by statute, his Lordship's statement was interpreted as denying the existence of the patient's privilege of confidentiality in relation to court testimony by his or her physician.

20 *Evidence Act* 1968 (Vic), s 28(2), provides that: "no physician or surgeon shall, without the consent of his patient, divulge in any civil suit action or proceeding or an investigation by a complaints investigator under the *Accident Compensation Act* 1985 (Vic), any information which he has acquired in attending the patient and which was necessary to enable him to prescribe or act for the patient."

21 *Evidence Act* 1910 (Tas), ss 87, 94, 96, 101.

22 *Evidence Act* 1939 (NT), ss 9(6), 10, 12.

23 Evidentiary prohibition in Victoria extends to "an investigation by a Complaints Investigator under the *Accident Compensation Act* 1985".

24 The coroner has wide powers of entry into premises and removal of records, as do the officers of the Transport Accident Commission and the Accident Compensation Commission (Vic) who have the power to enter "any premises" and inspect and copy records, which presumably includes doctors' files. Proceedings in relation to the sanity or testamentary capacity of the patient, actions to recover damages under Pt III of the *Wrongs Act* 1958 (Vic) and the *Accident Compensation Act* 1985 (Vic) are not covered by evidentiary privilege. Moreover, the evidentiary privilege is confined to State jurisdictions and does not extend to Commonwealth statutes.

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

26 *Medical Act* 1939 (Qld), s 35(ix)-(xi).

27 *Health Services Act* 1988 (Vic) (No 49 of 1988), s 141.

28 *PQ v Australian Red Cross Society & Ors* [1992] 1 VR 19, per

provisions makes it clear that the protection of a patient's confidentiality is lifted only during the course of the trial or other judicial proceedings concerning criminal matters; the exception does not apply at the stage of police investigations or inquiries. The offence of misprision of felony—failure to report an offence—has been abolished,[38] and, as long as the progress of the police inquiries is not hindered by acts of commission rather than omission, merely to refuse to answer their questions about a patient is not regarded as obstruction of the police.[39]

A medical practitioner who falls within the ambit of the above statutory confidentiality provisions, and who intends to disclose confidential information about the patient, whom he or she suspects to be "Mr Cruel", will have to act under the statutory "public interest" exception. This exception provides 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.*"[40] In other words, a medical practitioner must not act at his or her own discretion but should first obtain a *clearance* from the Minister to disclose confidential information.

It is arguable that, in creating the special confidentiality provisions which aim at preventing health-care providers from giving information leading to identification of their patients, the Parliament of Victoria decided that medical practitioners can best fulfil their obligations to society by fulfilling their duty to patients through proper application of those professional skills for which their training has prepared them, namely, the diagnosis, treatment and care of their patients, rather than by undertaking tasks which may jeopardise their mandate as healers.[41]

In Australia, neither the common law nor statutes construe the duty of medical confidentiality in absolute terms—the confidential information has to be disclosed under statutory or judicial compulsion. At the same time, in all States and Territories of Australia, a breach of the patient's confidentiality, which cannot be justified at common law or under statute, may expose the medical practitioner to a civil action, professional disciplinary proceedings and, in particularly notorious cases, to criminal charges.

Disclosure at common law

What does the common law say about voluntary, non-consensual disclosure of confidential information by a medical practitioner?

The positive duty of disclosure at law in respect of a *dangerous patient* has attracted attention, mainly in the United States of America, through the case of *Tarasoff v Regents of the University of California.*[42] In this case, Prosenjit Poddar, a graduate student at the University of California, in 1969 informed his psychotherapist, Dr Moore, that he intended to kill an unnamed but identifiable girl (Tatiana Tarasoff) on her return home from holiday in Brazil. When Dr Moore found out that Poddar 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. Having apparently secured from Poddar a promise that he would avoid Tatiana, the campus police

[28] *Continued*
McGarvie J, referring to s 141(2) of the *Health Services Act* 1988 (Vic). There are similar legislative requirements of confidentiality in the *Health Administration Act* 1982 (NSW); *Health Commission Act* 1976 (SA); *Health Services (Conciliation and Review) Act* 1987 (Tas).

[29] *Mental Health (General Amendment) Act* 1990 (Vic) (No 32 of 1990), s 120A. Any person who falls within the ambit of s 120A "must not . . . give to any other person, whether directly or indirectly, any information acquired by reason of being a person to whom this section applies, if a person who is or has been a patient in, or has received services from, a relevant psychiatric service could be identified from that information".

[30] Persons bound by the confidentiality provisions include proprietors and members of boards, as well as any person engaged or employed by any State- or privately-run psychiatric services as well as public or private general hospitals.

[31] *Mental Health Act* 1986 (Vic), s 120A(2).

[32] *Mental Health Act* 1986 (Vic), s 120A(2); *Health Services Act* 1988 (Vic), s 141(2). According to s 52 of the *Interpretation of Legislation Act* 1984 (Vic), the prescribed penalty of 50 penalty units amounts to a summary offence to be decided upon by the Magistrate's Court.

[33] The *Mental Health Act* 1986 (Vic), s 120A(2)(a), provides that a patient's confidentiality in respect of identification can be breached to "the extent necessary" to enable the disclosing person to carry out his or her functions and/or to exercise powers either under this or any other Act. Likewise, confidentiality provisions under s 121A(2) do not apply in cases where a person is expressly authorised or permitted to give information pertaining to a patient under the *Mental Health Act* or any other Act.

[34] *Health Services Act* 1988 (Vic), s 141(3)(a); *Mental Health Act* 1986 (Vic), s 120A(3)(a). If the patient has died, consent for disclosure can be lawfully obtained from the senior available next of kin.

[35] *Health Services Act* 1988 (Vic), s 141(3)(e); *Mental Health Act* 1986 (Vic), s 120A(3)(e).

[36] *Health Services Act* 1988 (Vic), s 141(3)(c); *Mental Health Act* 1986 (Vic), s 120A(3)(c).

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".

In the course of the 1976 judgment, Judge Tobriner of the Supreme Court of California 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 another person, has a positive duty to exercise reasonable care to protect the threatened victim and:

> "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."[43]

The Supreme Court of California held that the importance of ensuring the secrecy of *psychotherapeutic communication* between patient and doctor was outweighed by the public interest in the protection of third parties from violent attack. The principle that a therapist has a positive duty to exercise reasonable care to protect the threatened victim who is not his or her patient through disclosure of confidential information, has come to be known as the *Tarasoff Two* principle. The particular presumption postulated by *Tarasoff Two*, that the public interest in preventing the risk of harm posed by a potentially dangerous patient should generally override the public interest in the protection of a patient's confidences, has not been considered by the High Court of Australia.

However, in 1985, the Australian High Court, in the case of *Sutherland Shire Council v Heyman & Anor*,[44] reaffirmed the principle that, in general, common law does not impose a prima facie duty to rescue, safeguard from or warn another person of a reasonably foreseeable injury. The High Court held that a failure to do a positive act will not be regarded as negligent in Australian law, unless the defendant had some prior duty to do the act, or to prevent the injury that ensued. Such a duty could arise from statute or from the defendant's own antecedent conduct, for instance where the defendant's conduct has created the risk of injury to the plaintiff, or has increased such risk. The duty of positive action may also arise in circumstances where the plaintiff specifically relies upon the defendant to act to prevent an injury to him, and the defendant knows or ought to know of such reliance. It is unlikely that either one of the above prerequisites to the imposition of a positive duty of care would apply to a doctor whose patient has expressed threats directed towards a third person, where the latter is not a patient of the medical practitioner.[45]

The *Tarasoff* case was one where the intent to commit a crime had been disclosed, rather than one of a patient confessing to a crime that had already been committed. It may be argued that nonconsensual disclosure of certain information provided in the course of a therapeutic relationship could be justified on grounds which are analogous to the common law defence of necessity. Where a medical

[37] *Health Services Act* 1988 (Vic), s 141(3)(b); *Mental Health Act* 1986 (Vic), s 120A(3)(b).

[38] The common law offence of misprision of treason still exists.

[39] V D Plueckhahn and S M Cordner, *Ethics, Legal Medicine and Forensic Pathology* (2nd ed, Melbourne University Press, Melbourne, 1991), p 100.

[40] *Mental Health Act* 1986 (Vic), s 120A(3)(h)(i) (emphasis added). It may also be noted that s 120A(3)(c)(ii) of the same Act states that it is permissible to communicate confidential information to "the next of kin or near relative of the patient in accordance with the recognised customs of medical practice".

[41] M A Peszke, "Duty to the Patient or Society: Reflections on the Psychiatrist's Dilemma", in S F Spicker, J M Healey and H T Engelhardt (eds), *The Law-Medicine Relation: A Philosophical Exploration* (D Reidel Publishing Co, Dordrecht, 1978).

[42] *Tarasoff v Regents of the University of California I* 118 Cal Rptr 129; 529 P 2d 553 (1974) (vacated); *Tarasoff v Regents of the University of California II* 17 Cal 3d 425; 131 Cal Rptr 14; 551 P 2d 334 (1976); R Slovenko, "The Therapist's Duty to Warn or Protect Third Persons: Commentary" (1988) 16 *Journal of Psychiatry and Law* 139.

[43] *Tarasoff v Regents of the University of California II* 17 Cal 3d 425; 131 Cal Rptr 14; 551 P 2d 334 at 347 (1976).

[44] *Sutherland Shire Council v Heyman & Anor* (1985) 157 CLR 424.

[45] D Mendelson and G Mendelson, "Tarasoff Down Under: The Psychiatrist's Duty to Warn in Australia" (1991) 19 *Journal of Psychiatry and Law* 33.

practitioner performs therapeutic procedures to which the patient has not consented, the doctor may have a defence of necessity to liability in battery if he or she can show that the treatment was urgently necessary for the protection of the life or for the preservation of the health of the patient. It is doubtful, however, that the doctrine of necessity should be stretched to encompass breach of duty in order to warn, and thus possibly protect, a third party, even where the third party is an identifiable person. In the case of "Mr Cruel", the objective of the disclosure urged by the confidential letter was to help the police apprehend the offender and thereby protect some unidentifiable potential victim.

If, except in narrowly defined circumstances, the common law does not impose upon a medical practitioner a general duty to warn and protect third parties through voluntary, unauthorised disclosure of confidential information, can such a disclosure be justified on wider public interest grounds?

In the very passage in which Lord Mansfield denied the existence of an absolute privilege of medical confidentiality in respect of court proceedings, his Lordship also emphasised that the physician should never volunteer an unauthorised disclosure of confidential information. Nearly 200 years later, Lord Justice Boreham, in *Hunter v Mann*,[46] echoed Lord Mansfield's disapproval of the voluntary breach of medical confidentiality when he wrote:

> "the doctor is under a duty not to [voluntarily] disclose, without the consent of his patient, information which he, the doctor, has gained in his professional capacity."[47]

However, the common law has since recognised that there may be exceptions to the prohibition upon voluntary disclosure of confidential information. In the 1988 *Spycatcher* case,[48] Lord Goff of Chieveley formulated three common law principles which may limit the scope of the legal duty of confidentiality. The first principle refers to the fact that the duty of confidentiality applies only to information which has not entered the public domain.[49] It is arguable that *Tarasoff* comes within the first exception to the duty of confidentiality, namely, that the information disclosed was already in the public domain. In that case, Poddar's threats against Tatiana Tarasoff were not secret. They were known to the University of California campus police and to Tatiana's brother. The victim's parents sued the psychotherapist because the police enjoyed governmental immunity and there was no financial advantage in suing their own son. The psychotherapist was a perfect defendant: he had no immunity from suit and had professional indemnity insurance.

The second limiting principle excludes trivial and useless information from the scope of the duty. The third principle which may limit, or even nullify, the duty of confidentiality is based upon public interest, which Lord Goff of Chieveley defined 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 the law, nevertheless that public interest may be outweighed by some other countervailing public interest which favours disclosure."[50]

[46] *Hunter v Mann* [1974] QB 767.

[47] Ibid at 772.

[48] *Attorney-General v Guardian Newspapers Ltd (No 2)* [1988] 3 WLR 776 (the *Spycatcher Case*).

[49] Ibid at 806. *Tarasoff v Regents of the University of California I* 118 Cal Rptr 129; 529 P 2d 553 (1974) (vacated); *Tarasoff v Regents of the University of California II* 17 Cal 3d 425; 131 Cal Rptr 14; 551 P 2d 334 (1976).

[50] *Attorney-General v Guardian Newspapers Ltd (No 2)* [1988] 3 WLR 776 at 807.

The duty of professional confidence and common law principles limiting the scope of this duty, together with guidelines of ethical conduct in respect of professional secrecy, were adopted by the English Court of Appeal in two recent cases. In *W v Egdell*,[51] the patient-plaintiff, W, shot dead five people and seriously wounded two others in 1974. Subsequently he was diagnosed as suffering from paranoid schizophrenia and detained without the limit of time in a secure hospital. In 1986, W, through his solicitors, sought a report from an independent consultant psychiatrist, Dr Egdell, the subsequent defendant. Dr Egdell reported that W was suffering from paranoid psychosis and psychopathic personality rather than from schizophrenia. When it became clear to Dr Egdell that the solicitors did not intend to use his report, he supplied the copy of the report to the medical director of the secure hospital. W sued Dr Egdell for breach of confidentiality.[52]

In the second case, that of *Crozier*,[53] the accused, Crozier, pleaded guilty to attempted murder.[54] Crozier's defence counsel appeared at the sentencing hearing unaware that his own instructing solicitors had commissioned a medical report from a consultant psychiatrist, Dr McDonald, and therefore did not mention it to the sentencing judge. The psychiatrist's report stated that Crozier was suffering from a mental illness of a psychopathic nature which warranted detention in a special hospital. Dr McDonald arrived in court in time to hear the judge pass a sentence of nine years imprisonment. He 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 restrictive hospital order, which was granted. Appealing against the indeterminate hospital order, Crozier also put in issue the propriety of the psychiatrist's action in revealing privileged information, claiming that he would not have agreed to the disclosure.

In these two cases, the Court of Appeal decided that the public interest in disclosure of the relevant medical diagnosis overrode the competing public interest that there should be confidentiality between doctor and patient. It should be noted, however, that both in *Egdell* and *Crozier* the consultant psychiatrists were not in a therapeutic relationship with the respective plaintiffs. W (in *Egdell*) and Crozier were seen for medico-legal assessment at the request of their respective referring solicitors. The issue of the disclosure of the patient's identity did not arise, since the very purpose of these consultations was the disclosure to and on behalf of a third party though, admittedly, the informants had the right to decide who should receive data contained in the reports.

Moreover, the information disclosed by the consultant psychiatrists did not contain any material which was secret by virtue of a confidential relationship. Rather, the disclosure became controversial because the respective diagnoses about the patients' current mental condition were seen as adverse to the patients' 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 authorisation prima facie in breach of the duty of confidentiality,

[51] *W v Egdell & Ors* [1989] 2 WLR 689; *W v Egdell* [1990] 2 WLR 471.

[52] The case was originally heard in 1988 by J Scott in the Chancery Division, and later on by the Court of Appeal in 1989. Leave to appeal by the defendant to the House of Lords from the decision of the Court of Appeal has been refused.

[53] *Crozier* (1990) 12 Cr App R (S) 206.

[54] 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 passerby intervened and prevented the attack from going further.

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, in each individual case, to balance the interest to be served by non-disclosure against the interest served by disclosure. Thus, in England, the doctor who without consent or statutory authorisation breaches his or her duty of confidentiality always risks the threat of litigation at common law. Similarly in Australia, in cases where a medical practitioner in the course of a therapeutic relationship becomes aware that the patient has committed a crime or has confessed to anti-social conduct, will act at his or her own peril by breaching the duty of professional secrecy.

It is true that where, in breach of duty of confidentiality, the medical practitioner voluntarily discloses privileged information about the patient which then leads to the latter's arrest, trial and conviction, it will be most unlikely that the patient will have a legal remedy against the medical practitioner. This is because such a patient will be unable to show that, as a result of the unauthorised disclosure, he or she had suffered damage of the kind which the law would recognise as compensable damage.[55] It is equally true that, if the patient who can trace his or her arrest and trial to the doctor's breach of confidentiality is acquitted, then an action may be brought against the doctor for both breach of the medical duty of confidentiality and, depending upon the form of the disclosure, either defamation or slander. It should also be remembered that where patients find out that their medical practitioner has disclosed their identity to the police on suspicion of murder or some other indictable offence, such patients may pose a very serious personal risk to the doctor.

In conclusion, as the confidential letter points out, a breach of the medical duty of confidentiality is a serious matter. A medical practitioner who has to decide whether or not to disclose confidential identifying information about a patient must consider not only what he or she thinks is morally right in conscience and in professional ethics, but also in law.

[55] Plueckhahn and Cordner, op cit n 39, p 101.