

# Defining the physician's duty to warn: consensus statement of Ontario's Medical Expert Panel on Duty to Inform



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## Abstract

ONTARIO'S MEDICAL EXPERT PANEL ON DUTY TO INFORM was formed to consider the duty of Ontario physicians in circumstances where a patient threatens to kill or cause serious bodily harm to a third party. The panel was concerned about the implications of any duty to inform on the integrity of the physician-patient relationship, particularly with respect to confidentiality. The panel agreed that regulations safeguarding the confidentiality of patient information ought to be changed only if there is a critical reason for doing so, but, after deliberation, the panel members concluded that the need to protect the public from *serious risk of harm* is a paramount concern that should supersede the duty of confidentiality. The recommendations reported here were endorsed in principle by the panelists and the groups they represented (the Royal College of Physicians and Surgeons of Canada, the Canadian Medical Protective Association, the College of Physicians and Surgeons of Ontario, the Ontario College of Family Physicians and the Ontario Medical Association) and are being implemented by the College of Physicians and Surgeons of Ontario.

## Résumé

LE GROUPE D'EXPERTS MÉDICAUX DE L'ONTARIO sur l'obligation d'informer a été chargé d'étudier l'obligation qui incombe aux médecins de l'Ontario lorsqu'un patient menace de tuer quelqu'un ou de lui causer de graves préjudices corporels. Le groupe de travail a étudié les répercussions que toute obligation d'informer pourrait avoir sur l'intégrité de la relation médecin-patient, surtout en ce qui concerne la protection des renseignements personnels. Le groupe de travail a convenu qu'il faut une raison cruciale pour modifier les règlements protégeant la confidentialité des renseignements personnels des patients mais, après délibération, les membres du groupe ont conclu qu'il reste primordial de protéger le public contre un «*grave risque de préjudice*» et que cette nécessité doit l'emporter sur l'obligation de protéger les renseignements personnels. Les recommandations énoncées ici ont été approuvées en principe par les membres du groupe et les organismes qu'ils représentent (le Collège royal des médecins et chirurgiens du Canada, l'Association canadienne de protection médicale, le Collège des médecins et chirurgiens de l'Ontario, le Collège des médecins de famille de l'Ontario et l'Association médicale de l'Ontario) et le Collège des médecins et chirurgiens de l'Ontario procède actuellement à leur implantation.

**T**he question of whether a physician has a duty to divulge confidential information when a patient reveals a plausible intention to do serious harm to a third party has been the subject of debate within the medical community in recent years. In Canada, the confidentiality of patient information is protected by statute except in certain circumstances; specifically, physicians are required to provide information about a patient without his or her consent to protect society (e.g., when a patient is medically unfit to drive). However, these

## Education

## Éducation

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For the purposes of this panel, Dr. Barkun represented the Royal College of Physicians and Surgeons of Canada, Dr. Carlisle represented the College of Physicians and Surgeons of Ontario, Dr. Hoffman represented the Ontario Medical Association, Ms. Katz represented the Ontario College of Family Physicians, and Dr. Silverman represented the Canadian Medical Protective Association.

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exceptions do not include situations in which a patient threatens to seriously harm someone. In such situations, the courts have found that a common-law duty to protect the public, known as the “duty to warn” or “duty to inform,” outweighs the physician’s duty of confidentiality to the patient. These precedents indicate that this common-law duty is likely to be applied.

Despite the possible common-law duty obliging physicians to inform the authorities or the threatened party (or both), physicians are currently prohibited by regulation from revealing information about the condition of a patient or any services rendered to him or her without the consent of the patient or an authorized representative (unless specifically required or permitted by law); doing so could result in disciplinary action. In Quebec, physicians are permitted to reveal facts that have come to their attention if there is “just and imperative motive” related to the health of the patient or the welfare of others.<sup>1</sup> In Ontario, for example, this prohibition is stated in regulations under the Medicine Act.<sup>2</sup>

Physicians may thus feel caught between 2 principles — confidentiality and public safety — and may be uncertain as to their duty. This lack of clarity could lead to confusion about the appropriateness of various actions and, in some cases, to divergence in practice.

The need to clarify what is expected of physicians in these circumstances was the impetus for convening Ontario’s Medical Expert Panel on Duty to Inform. The panel was concerned with whether there is any regulatory obligation or duty for a physician to inform authorities or the potential victim about a threat of harm. The panel also set out to review these expectations within the context of the legal system to ensure their congruence with existing legal obligations. If, after its review, the panel concluded that current legal obligations themselves should be challenged, it would also identify this need.

The panel comprised representatives from 5 regulatory and professional organizations — the Royal College of Physicians and Surgeons of Canada, the Canadian Medical Protective Association, the College of Physicians and Surgeons of Ontario, the Ontario College of Family Physicians and the Ontario Medical Association. The panel’s recommendations were based on a comprehensive analysis of the relevant medical and legal literature. The panelists discussed their deliberations with their respective organizations and sought their input. At the conclusion of its deliberations, the panel drafted a set of recommendations for review by the participating groups. The final recommendations incorporated feedback from these organizations, each of which endorsed the recommendations in principle. The final recommendations are now being implemented by the College of Physicians and Surgeons of Ontario.

## Confidentiality versus public peril

Confidentiality is an integral component of practice of medicine, and communication between a patient and a physician is protected against improper disclosure. The principle of confidentiality rests on 4 premises: (1) individual human autonomy, (2) respect for relationships, (3) respect for promises to protect shared information and (4) the benefits of confidentiality to those in need of advice, sanctuary and aid and, in turn, to society.<sup>3</sup> Physicians are constrained from disclosing any information obtained from a patient unless specifically authorized by the patient or a proxy or as otherwise required or permitted by law. The current statutory exceptions to the principle of confidentiality (e.g., with respect to suspected child abuse, medical unfitness to drive or operate an aircraft, certain infectious diseases, reports related to workers’ compensation, certificates under the Vital Statistics Act and court subpoena) place the protection of the public above the interests of the individual, and a physician may be subject to prosecution and penalty for failure to fulfil these obligations. No federal or provincial statutes specifically require or permit physicians to report patients who make plausible threats to seriously harm others, although provincial mental health legislation may provide for confining these patients to psychiatric facilities, in appropriate circumstances.

## The duty to warn: legal precedents

It is well accepted in law that there are occasions when a physician’s duty to the public outweighs the principle of confidentiality, and the duty to warn about potentially violent patients is one such occasion. This is a common-law rather than statutory duty. The legal definition of “duty to warn” was first introduced in a 1976 landmark decision by the California Supreme Court,<sup>4</sup> in which it was held that “the privilege [of confidentiality] ends where the public peril begins.” Controversy in the United States about the rulings in this case<sup>5-18</sup> has in recent years focused on the lack of clarity for those trying to meet this obligation.

The original decision in this case (Tarasoff I) stated, “When a doctor or psychotherapist, in the exercise of his professional skill and knowledge, determines or should determine, that a warning is essential to avert danger . . . He incurs a legal obligation to give a warning.”<sup>4</sup> A subsequent appeal led to the Tarasoff II decision, a key component of which is referred to as the Tarasoff principle: “When a psychotherapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger.”<sup>19</sup> This duty might



call for a therapist to warn the intended victim or someone likely to apprise the victim, to notify the police or to take whatever other steps are reasonably necessary.<sup>19</sup>

The balancing act between maintaining physician-patient confidentiality and protecting the public has also been an issue in Canada. Although the Tarasoff judgment is not binding in this country, it has been cited by Canadian courts in similar circumstances, as in *Wenden v. Trikha*.<sup>20</sup> In this case a patient was voluntarily admitted as a psychiatric patient to a general hospital in Alberta. He had previously been reluctant to take his medications regularly because of possible side effects, complaining in particular of problems while driving. However, on admission to hospital, his car keys were not confiscated. He escaped, despite being under close supervision (checks at 15-minute intervals) and drove his car at high speed into another car, injuring a third party. The judge found that the patient had been negligent, whereas the psychiatrist of record and the hospital had acted appropriately and were therefore not liable. The court concluded that a psychiatrist who knows that a patient poses a serious threat of violence to the public must take reasonable steps to protect the public, although it was felt that nothing could have been done in this particular case. The court established a duty to inform based on the "neighbour principle," which comes from an English decision (in *Donoghue v. Stevenson*) stating that in law the rule to "love your neighbour" becomes "you must not injure your neighbour."<sup>21</sup> In the Alberta decision, the court concluded that it is fair and reasonable that a hospital or a psychiatrist who becomes aware that a patient presents a serious danger to a third party have a duty to take reasonable steps to protect the third party, but only if the proximity of the relationship between the patient and the third party meets the limits of the neighbour principle.

In *Wellesley Hospital v. Lawson*<sup>22</sup> a psychiatric patient who had been assessed as violent and who was being held on a secure ward escaped and assaulted Lawson, another patient in the hospital. The Supreme Court of Canada upheld the finding of liability against the hospital for failing to protect all of its inpatients. This case is significant because it has implications for those treating patients known to be dangerous who pose a potential threat to a large population rather than to a specific individual.<sup>23</sup>

In *R v. Ross* a law student was convicted of sexual assault against a woman.<sup>24</sup> A Nova Scotia psychiatrist who had previously treated the complainant learned of the conviction through the media and contacted the Crown counsel to express concern about the complainant's credibility. However, he refused to open his files or discuss the matter further without the former patient's consent. When consent was refused, the accused applied to have the records examined, and the court granted a restrictive "order for

discovery." On the basis of testimony by the psychiatrist and new evidence regarding the complainant's sexual conduct with another person, the Nova Scotia Court of Appeal allowed the appeal, stating that the "public interest in avoiding an injustice was more important than the doctor-patient privilege."

In terms of liability, most cases in the US have been initiated by injured third parties who were not warned. Some patients have attempted to sue their psychiatrists for failing to prevent them from committing a crime,<sup>25</sup> but the courts have ruled that someone convicted of a criminal offence cannot ascribe civil liability to someone else (although those found not guilty on grounds of mental disorder may sue successfully).

### Duty to warn and the physician-patient relationship

There has been debate within the medical community as to whether there should be exceptions to the obligation to protect patient confidentiality. For example, Siegel<sup>26</sup> originally argued for safeguarding the therapeutic relationship by absolute confidentiality but later modified this stance to comply with the law. Others feel that therapy can be conducted without complete confidentiality.<sup>3,27</sup> Bok<sup>3</sup> stated that the point at which individual autonomy must yield to the rights of others is often stipulated in law. For Bok, protection of confidentiality should be overridden when maintaining it "would allow violence to be done to innocent persons, or turn someone into an unwitting accomplice in crime."

There has been concern that a duty to warn will lead to a lack of trust in therapists or a reduction in the number of therapists willing to treat potentially violent patients.<sup>7,12-18</sup> However, we already have examples of breach of confidentiality for the welfare of society and the individual, so creating a duty to warn does not set a precedent.<sup>28,29</sup> Patients who are routinely warned about the limits of confidentiality do not seem to have difficulty relating to and working with their therapists.<sup>30</sup> Some professionals believe that failing to protect a patient from carrying out acts that might lead to a criminal investigation, legal proceedings and conviction could harm the patient by reducing freedom and impairing access to therapy; therefore, warning the potential victim also acts to safeguard the therapeutic relationship.<sup>11</sup> The therapist who reports a serious threat shows the patient that he or she cares enough to set limits on the patient's self-destructiveness and demand that the patient act responsibly toward self and others.<sup>11</sup> The revelation to a professional of intent to commit self-destructive acts is often correctly interpreted as a cry for help, and one could extend that argument to cover instances where the threats involve third



parties. In *McInerney v. MacDonald*, the Supreme Court of Canada ruled that health care professionals are compelled to use medical records in their patients' interests.<sup>31</sup> In other words, protecting the interests of both a potential victim and the potential assailant are not necessarily incompatible.

The existence of a duty to warn does not mean that therapists must take action whenever a threat is verbalized. Threats that therapists deem unlikely to be acted upon do not invoke the duty to warn because no harm is foreseeable.<sup>5,10</sup> Moreover, it is recognized that there may be therapeutic gains from discussing violence<sup>9,12</sup> and discovering and reviewing rage and violent fantasies in treatment.<sup>9</sup>

Pivotal to the duty to warn is the assessment of the dangerousness of the patient. In the *Tarasoff* case, 1 of the 3 failed defences was the inability to detect dangerousness. The American Psychiatric Association supported that defence, stating in a brief that psychiatrists can profess no special accuracy in predicting the danger posed by an individual patient. According to Dickens,<sup>23</sup> the literature published since the *Tarasoff II* decision has established the limits of psychiatric prediction: what is required is a competent level of professional performance, not accuracy, and the duty is to act appropriately on a competently made prediction.<sup>23,32</sup> A well-thought-out judgement based on professional responsibility is always the best defence,<sup>18</sup> and a competent but incorrect finding will not lead to legal liability. Although reporting verbalized threats will involve reporting "false positives," the level of misdiagnosis will not be as high as it would be if therapists were required to predict dangerousness.<sup>11</sup>

From a Canadian perspective, Roy and associates<sup>33</sup> have added that psychiatrists realistically and pragmatically cannot be expected to refuse to predict dangerousness, but those predictions should at least be tightly controlled. The critical point is the difficulty in making reliable predictions of dangerousness in the long term, and the authors questioned how long patients can justifiably be kept in protective custody. For US physicians and therapists, a major concern remains the possibility of being held liable if they fail to correctly assess dangerousness. In a 1990 review Beck concluded that there had been only 4 published cases in which liability for breach of the *Tarasoff* principle was found.<sup>34</sup> The courts have held that there is a duty to protect when the violence is foreseeable and the clinician has "sufficient control over the patient's behaviour to prevent violence."<sup>34</sup> The issue of control is partly related to whether the patient is an inpatient or an outpatient: "sufficient control" by the clinician was found in only half of outpatient cases but in almost all cases involving the release of an inpatient.<sup>34</sup> Greenberg<sup>17</sup> has written that case law antedating the *Tarasoff* judge-

ment recognized that the relationship between a therapist and a patient generated a specific duty to control the patient or decrease the risk of the threat when he or she is determined to be dangerous to self or others. However, the *Tarasoff* case was unique because it involved an outpatient and because the therapist was deemed to have a responsibility to protect the intended victim in addition to attempting to control the patient.

Most often, the overriding issue determining liability in the assessment of dangerousness has been the failure to conform to "usual professional standards." Liability is found not in the inability to predict but in the failure to exercise due care in assessing violence. Simon<sup>25</sup> claimed that the best protection against being found negligent in an assessment of dangerousness is to use methods that incorporate variables associated with violence and to carefully document how and when the assessment is conducted. He distinguished between assessing violence and assessing dangerousness, saying that clinicians assess the risk of violence, not dangerousness, which is a legal construct.<sup>35</sup> He claimed that "dangerousness" is a function of the dynamic interaction between a specific individual and a specific situation for a given period of time and is not something that clinicians can assess.

A recent review of the literature indicated that risk assessment for acute violence to third parties is effective.<sup>36</sup> In essence, the authors found that (1) risk assessment is an important and necessary part of the clinical examination and that these assessments are valid for short-term prediction,<sup>37-40</sup> usually 1 week or less; (2) clinical standards of practice in the area of risk assessment for acute violence to third parties can be developed; and (3) there are identified factors that, when taken together, are the most common predictors of imminent danger and cannot be ignored.<sup>36</sup> The review identified the factors that have been used in most duty to warn statutes in the US.<sup>36</sup> Factors considered "immediate and clear" are those that can be identified by physicians regardless of medical specialty. In less clear cases, there is sufficient clinical and research data about risk assessment to allow physicians to conduct (or have a colleague conduct) the assessments that would be valid for short-term prediction.<sup>36</sup> The review also emphasized the importance of assessing the situation each time a patient threatens serious harm, even if similar threats have not been carried out in the past.

## Key recommendations of Ontario's Medical Expert Panel on Duty to Inform

The panelists agreed that their recommendations should rest on the following principles:

- Physicians should have a duty to inform a third person when a patient threatens to cause serious harm to an-



other person or persons and it is more likely than not the threat will be carried out. The need to protect the public from likely risk of serious harm supersedes a physician's duty to keep patient information confidential.

- There should be a standard of practice for the assessment of risk when a threat is made, and this standard should be enforced.

Table 1 presents the key recommendations of the panel, which have been published in full elsewhere.<sup>41</sup> They are intended to protect the public from serious harm, to prevent patients from causing serious harm to themselves by carrying out threats and to protect physicians by ensuring that there is no legal or professional liability for those who, in good faith, disclose that a patient has a plan to seriously harm a third party. The recommendations also cover cases in which the potential victim is not identifiable (e.g., a threat to bomb a building, derail a train or shoot the next police officer the patient sees).

The panel had specific reasons for recommending mandatory standards rather than guidelines. The panelists believed that a discretionary duty would not adequately protect either potential victims or physicians. Potential victims ought to have the opportunity to take measures to protect themselves, and a discretionary duty might be insufficient to warn all potential victims equally. Moreover, physicians cannot be sure that an adequate treatment facility is available or that a patient is receiving appropriate treatment, which reinforces the need for potential victims to have a chance to protect themselves. It may be easier for physicians to continue caring for their patients if they are required rather than merely permitted to inform. A mandatory duty may make it easier to defend physicians who, in good faith, report a patient's threats, since professional liability could be found only for not reporting rather than for, depending on the situation, reporting or not reporting. Ontario lawyers have a rule of confidentiality that is as strict as that of physicians, but they also a mandatory duty to inform when they have reasonable grounds to believe that a violent crime is likely to be committed.<sup>42</sup>

The panel felt that to deal with serious risk of violence, a benchmark must be set that balances the duty of confidentiality and protection of the public and that considers the validity of risk assessments; the phrase "more likely than not" (that the violence will be carried out) was seen to express that balance. The panel recognized that patients often make therapeutic gains by discussing violence. Therefore, if a patient has threatened serious harm and the physician believes that there is less than a 50% chance that the threat will be carried out, there would be no duty to inform. If the physician believes that there is an even or greater than even chance that the violence will occur, he or she would be obliged to inform the potential victim and, simultaneously, to try to help the patient.

The panel considered whether detaining a patient in a psychiatric facility would protect the public such that disclosing confidential information would be unnecessary. Although this option was appealing, the panel rejected it for several reasons: protecting the public from the risk of

#### Key recommendations of Ontario's Medical Expert Panel on Duty to Inform\*

There should be a duty to inform when a patient reveals that he or she intends to do serious harm to another person or persons and it is more likely than not that the threat will be carried out. The panel describes factors by which this judgement should be made.<sup>41</sup>

A standard of practice in this regard should be established by the College of Physicians and Surgeons of Ontario, and the regulations defining professional misconduct should be amended to provide for such notification.

Where a threat is directed at a person or group and there is a specific plan that is concrete and capable of commission and the method for carrying it out is available to the threatener, the physician should immediately notify the police and, in appropriate circumstances, the potential victim.

The report should include the threat, the situation, the physician's opinion and the information upon which it is based.

In less clear circumstances, the physician should conduct or have conducted by a colleague a clinical assessment of the risk of violence conforming to the standards described in these recommendations. If the assessment indicates that it is more likely than not that the violence will occur, a similar report should be made.

Taking all the circumstances into account, physicians will want to consider very carefully whether they should report threats and will, if there is any doubt, err on the side of informing the police because of the potential seriousness of the consequences in the event that they decide not to inform.

The profession should define the standard of practice concerning clinical assessments for risk of violence and inform physicians of the standard. It will be important to re-emphasize to physicians who are uncertain about whether a situation invokes the duty to inform that they should seek assistance by consulting with their professional college or with their private solicitor or legal defence association. It is important that physicians be aware that it is the gravest matter, giving rise to serious risk of being thought to have misconducted oneself, not to abide by the standard of practice in this or any other regard.

Physicians should maintain careful documentation of the threat, the clinical assessment and the action(s) they took to meet their duty to inform or otherwise. They should take every practical precaution to avoid inaccuracy and unfairness in their reporting and convey the information in a clear manner so that there is no ambiguity about the identity of the patient, the identity of the potential victim, the circumstances or the seriousness of the potential danger.

Physicians may use other strategies to simultaneously deal with the patient and his or her threats.

If a person has threatened serious harm, the physician should assess the situation each time the threat occurs. It is not in keeping with the recommended standards of practice to ignore the threat because previous threats have not been carried out.

Medical schools and postgraduate training programs should include content about clinical assessments for risk of violence in their curricula.

\*The recommendations of the panel have been published in full elsewhere.<sup>41</sup>



serious harm would be contingent on the availability of adequate psychiatric facilities; only patients who were apparently suffering from a mental disorder could be detained under an application for psychiatric assessment, a certificate of involuntary admission or a certificate of renewal, and these would not encompass all cases of serious threat; the physician would be required to personally examine the patient, which would not allow for involuntary detention when a threat was made over the phone or in writing; physicians completing an application for psychiatric assessment would not necessarily know whether the patient had been involuntarily admitted (because there exists no formal tracking of certificates of involuntary assessment or admission, and physicians are not notified if a patient has been involuntarily detained or subsequently released; a ward or facility frequently will not or cannot provide an adequate level of security to deal with a patient who poses a serious threat to the public; and potential victim(s) would be less likely to have the opportunity to take precautions to protect themselves.

## Conclusion

A duty of confidentiality is an integral part of the physician-patient relationship. Dealing with situations in which there may be a limit to confidentiality is difficult at the best of times, and when there is no clear indication from professional bodies about what is expected, it may be impossible to balance priorities and responsibilities. In the case of patients who threaten serious harm to others, physicians could be left trying to balance their medical and regulatory responsibilities to not divulge confidential information with their legal responsibility to fulfil a common-law obligation to inform. The recommendations of Ontario's Medical Expert Panel on Duty to Inform make clear what the profession believes to be the appropriate action in these cases. Once implemented, these recommendations will give physicians the regulatory changes they need to meet the expectations of their profession.

However, the responsibility of the profession does not end here. More research is needed on the effective medical management of patients with violent tendencies, and further actuarial and clinical studies are needed to ensure that risk assessments remain current. Physicians should be involved in these studies and should press for research funding for this purpose.

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