THE PARAMETERS OF MEDICAL-THERAPEUTIC PRIVILEGE

by

DIETER WALTER WELZ

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SUPERVISOR : PROF S A STRAUSS

JOINT SUPERVISOR : PROF M C MARÈ

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1. THERAPEUTIC PRIVILEGE IN SOUTH AFRICA

Decisions dealing with the therapeutic privilege defence are notably absent in South African law. There are, however, a few *obiter dicta*, which may be seen as "starting points for the defence".[1] Thus Watermeyer J remarked in *SA Medical and Dental Council v McLoughlin*:[2] "It may sometimes even be advisable for a medical man to keep secret from his patient the form of treatment which he is giving him, and for a medical man to disclose to anyone, other than the patient, the form of treatment which he is carrying out, may amount to a breach of confidence between doctor and patient." This statement is in no way conclusive, however. It alludes to the issue of confidentiality in the context of the doctor-patient relationship and hardly even contains the rudiments of the therapeutic privilege defence. Somewhat more to the point is what Watermeyer J had to say in *Richter v Another and Estate Hammann*[3] when referring to the problems surrounding the so-called therapeutic privilege of the medical profession. He described the doctor's dilemma in a way that clearly contributed to the wider debate concerning the existence and the desirability or otherwise of this defence when he explained : "If he fails to disclose the risks he may render himself liable to an action for assault, whereas if he discloses them he might well frighten the patient into not having the operation when the doctor knows full well that it would be in the patient's interests to have it." Ackermann J, in the most detailed judgement[4] on informed consent delivered to date by a South African court, expressly acknowledged the existence of the therapeutic privilege defence in South African law, but left open the question what "the ambit of the so-called 'privilege' may today still be". Whilst not rejecting the defence out of hand, Ackermann J appears to hold the view that it does not accord fully

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1 Van Oosten "The so-called 'Therapeutic Privilege' or "Contra-Indication" 1991 *Med Law* 33.

2 1948 (2) SA 355 (A) at 336.

3 1976 (3) SA 226 (C) at 232.

4 *Castell v De Greef* 1994 (4) SA 408 (C) at 426.

with the present-day developments of our law which clearly promote patient autonomy and self-determination.[5] It was not necessary for the *Castell* court to spell out the ambit and parameters of the privilege and, accordingly, uncertainty prevails concerning its precise nature and role in what may be generally be described as non-disclosure actions.[6]

South African legal opinion, scant as it may be, appears to be unanimous in its acceptance in principle of the notion that in exceptional circumstances the duty to disclose may be suspended.[7] This is an exception to the general rule that ordinarily "a patient in a non-emergency case must be informed of the nature of the treatment and the substantial risks it holds for him"[8] or her. Such a withholding of information must be in the best interest of the patient himself, but may also be justified where full disclosure may create a substantial danger to a third party.[9] This common-sense view is widely supported in medico-legal literature and may predictably be upheld in suitable cases brought before South African Courts.[10] But then therapeutic privilege has received virtually no attention in the judgements of our courts so far, except for the few *dicta* mentioned above. As was observed above, the *Castell*[11] court did not find it necessary to pursue this issue further, because the therapeutic privilege was not invoked in that case to justify non-disclosure. Ackermann J acknowledged, however, that this issue forms "part of the wider debate concerning consent to medical treatment and whether emphasis should be placed on the autonomy

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5 See Dreyer "Redelike Dokter versus Redelike Patient" 1995 *THRHR* 538.

6 See Van den Heever "The Patient's Right to Know : Informed Consent in South African Medical Law" 1995 *De Rebus* 56.

7 See Van Oosten *op cit* - note 1 at 33 and Van Oosten *Consent* 60.

8 Strauss *Doctor* 10.

9 Giesen *MML* 382.

10 See Strauss *Doctor* 10 and Strauss *Legal Handbook* 7th ed (1992) 13.

11 *Castell supra* at 418.

and right of self-determination of the patient in the light of all the facts or on the right of the medical profession to determine the meaning of reasonable disclosure".[12]

In order to explore the parameters of the medical therapeutic privilege this wider debate must be entered. This paper therefore critically examines the nature and scope of the therapeutic privilege defence in non-disclosure cases in the context of the doctor's undisputed general legal-ethical duty to procure a properly informed consent from his patient and his equally undisputed medico-ethical duty to heal, which sometimes are in conflict.[13] That conflict constitutes the doctor's dilemma referred to in the *Richter*[14] case. The judicial formulations of the so-called therapeutic privilege defence are attempts to resolve this conflict equitably. How successful such attempts can be is a moot point and open to discussion as the legal literature on this point indicates. The judicial formulations of the privilege raise a number of questions.

To answer these questions I initially examine the different aspects of informed consent, focussing on the legal, ethical and clinical dimensions thereof. Then I explore the leading judicial formulations of the therapeutic privilege concept. Thirdly, I evaluate the ongoing debate concerning the parameters of the privilege in the light of the foregoing analysis.

2. THERAPEUTIC PRIVILEGE IN PERSPECTIVE

2.1 Introduction

The doctrine of informed consent came from America, but different jurisdictions

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12 *Ibid.*

13 See Van Oosten 1991 *Med Law* 31.

14 *Supra* at 232.

interpret it differently. Whereas the term informed consent has been rejected as inapplicable in Australia and England,[15] the *Castell*[16] court expressly accepted it as meaningful. It is used to uphold "the ethical principle of self-determination which underlies the legal principle of informed consent to medical treatment".[17] In other words, the legal requirement for consent expresses respect for the patient's autonomy. As a general rule patients cannot be required to accept treatment they do not want, no matter what the consequences are if they refuse to undergo it. It is this proposition that is recognised "as both an ethical principle and a legal rule";[18] its foundational principle is respect for the patient's autonomy or the patient's right to self-determination. This principle lies at the heart of the physician-patient relationship. Informed consent, ultimately, is a moral principle as applied to questions of medical ethics.[19] Its correlative is proxy consent which is invoked when dealing with a patient who is incompetent to give informed consent for one reason or another, as informed consent presupposes competence or "the capacity to make an autonomous decision using a well-informed conscience".[20]

The language of self-determination also prevails in the report of the American President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research : 1980 - 1983 (USA).[21] The Commission indicated that "the *sole* or *primary* value underlying its first-party consent provisions is respect for autonomy", describing the principle of self-determination as the cornerstone

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15 Earle, "Informed Consent : Is there Room for the Reasonable Patient in South African Law?" 1995 *SALJ* 629.

16 *Supra* at 426.

17 Earle *op cit* - note 15 at 629.

18 Jones *Medical Negligence* (1991) 200.

19 See Guevin "The Principles of Informed (Proxy) Consent and Totality in the Reputable Practice of Medicine" 1996 *American Journal of Jurisprudence* 189.

20 *Ibid* 199.

21 See Faden & Beauchamp *A History and Theory of Informed Consent* (1986) 98.

of its point of view.[22] It argued that the requirements of informed consent are "essentially moral and policy-oriented, rather than legal"[23] in spite of the fact that it primarily emerged from a history in law.

The Resource Document on the Principles of Informed Consent published by the American Psychiatric Association (APA)[24] accordingly decreed : "Informed consent has legal, ethical, and clinical dimensions." It elaborated on this distinction as follows: "a) From a legal perspective, it requires physicians to disclose certain classes of information to patients, and to obtain their consent before initiating medical treatment. b) In its ethical dimension informed consent encourages respect for individual autonomy in medical decision making. c) As a clinical process, informed consent offers a mechanism for collaboration between physicians and patients in identifying clinical problems and selecting appropriate treatment." The APA Document also pointed out that whereas legal requirements define the minimum criteria for an adequate informed consent process, their implementation and augmentation will be a reflection of an appropriate concern with ethical and clinical considerations. Law, ethics and bioethics are different yet related concepts that interact with each other in various ways. Whereas laws are mandatory rules, ethics is a set of moral standards while bioethics refers to moral issues and problems surrounding medical treatment and research. These standards can be personal, organisational, institutional or worldwide, but non-adherence to them does not incur the risk of civil or criminal liability, rather moral reproach and disapproval.

There are no legal sanctions attached to behaviour that is considered morally wrong, of course.[25] Moral standards are not legally binding rules. They set forth

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22 *Ibid* 99 *et seq.*

23 *Ibid* 99.

24 State Newsletter July/August 1996 (Internet).

25 See Lewis & Tamparo *Medical Law, Ethics and Bioethics in the Medical Office* 3rd ed (1993) 9.

universal goals instead which may evolve into foundational principles of legal rules, however. A direct conflict sometimes arises between the doctor's medico-ethical duty to heal and his or her legal-ethical duty to inform the patient in question adequately.[26] Such a conflict situation calls for a mechanism for conflict resolution. The so-called therapeutic privilege as an exception to the informed-consent requisite purports to be exactly that.

The nature and role of the therapeutic privilege remain matters of uncertainty, however, and present controversial issues relating to the informed-consent requisite. This controversy is aggravated by the fact that the creation of such an exception to the general rule definitely infringes upon the fundamental principle of patient autonomy : "The wider the scope of the therapeutic-necessity or contra-indication defence is defined, the narrower the scope of the informed-consent requisite becomes, and *vice versa*."[27] This has all the ingredients of a vicious circle, it seems, and certainly calls for a closer look at the parameters of medical therapeutic privilege in the wider context of informed consent as a complex legal, ethical and clinical process.

2.2 Legal Aspects of Informed Consent and Therapeutic Privilege

The medico-legal topic of informed consent is part of the wider issue of truth-telling in medicine which in turn is not primarily a legal matter, but concerns professional ethics. There is, however, "a definite legal dimension to the subject of truth-telling in medicine",[28] as the emergence of the defence of therapeutic privilege in American law has clearly demonstrated.

The presumption of self-determination as the foundational principle of the

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26 See Van Oosten 1991 *Med Law* 31.

27 *Ibid.*

28 Strauss *Doctor* 15.

doctrine of informed consent is the common-law analogue of the constitutional right to privacy, of course. Any attempt to curtail this basic human right by asserting a societal health interest or a duty to heal puts a heavy burden upon its proponents (the health-care providers) as they will have to show why this interest should prevail in a particular case.[29] The basis for the following discussion is, however, not an analysis based on a constitutional right of privacy, but rather of what might be termed a common-law analysis of the right of the individual to make medical decisions.

Informed consent becomes only operative once subjects have full and free access to all the necessary information that enables them to make appropriate health care decisions. For this reason their doctor must tell them the truth about their diagnosis and prognosis, of course. However, "the patient's right to be told the truth"[30] may be subject to the physician's therapeutic privilege in exceptional cases. This is a reference to "the legal doctrine" in terms of which doctors may be justified in withholding information from patients for two reasons, namely (1) "if they reasonably believe this information would not be in the patient's best interests" or (2) that it "would interfere with treatment and care".[31]

The debate on compulsory blood tests is reminiscent of controversy surrounding this doctrine. It "amounts to a showdown between the idea that the truth should be discovered whenever possible and the idea that personal privacy should be respected", as the court in *C v Minister of Correctional Services*[32] put it crisply, adding that the "resolution of that debate would depend largely upon the store the Court sets by each idea, on its own sense of priority in that regard", as both

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29 See Meisel "The 'Exceptions' to the Informed Consent Doctrine : Striking a Balance between Competing Values in Medical Decision-Making" 1979 *Wis L Rev* 431 n 70.

30 Williams "Ethics in Cross-Cultural Health" in Masi *et al* (eds) *Health and Culture : Exploring the Relationships* (1993) 263.

31 *Ibid.*

32 1996 (4) SA 292 (TPD) at 300.

ideas are important, but neither sacrosanct. In other words, judicial policy is the decisive factor in this matter.

In the context of HIV and informed consent the argument for medical discretion appears to discard the idea of respect for personal privacy completely when it is stated as follows: "The matter of undefinable 'informed consent' for blood testing for HIV infection, as anticipated, has become ludicrous. .... Unless doctors, as has always been customary, are free to investigate as they see fit, the epidemic will never be quantified and controlled."[33] The veiled reference to traditional medical paternalism cannot go unnoticed in this context. The advocated infringement of the individual's right to make medical decisions based on informed consent indicates that the patient's right to know is seen as contingent upon some sort of therapeutic privilege of physician's to withhold information where non-disclosure would appear to be in the societal interest of controlling an epidemic that threatens the very fabric of society.

This view is in stark contrast with informed consent as a social policy which does not accept the paternalistic presumption that the patient's right of self-decision should be suspended where this, in the physician's subjective opinion, might be in the patient's, as well as in society's best interests.[34]

As the doctrine of informed consent tends to the expansion of liability of the medical profession, significant inroads into the doctrine can only occur in a climate of judicial policy (if any such policy can be identified) discouraging such expansion. In South Africa the present judicial climate seems to be strongly in favour of the patient's right of self-determination and a policy of informed consent, with such a right as its basic premise. In view of this fact, the

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33 Fennel "HIV and Informed Consent" (letter) 1996 *AIDS Scan* 14.

34 See also the American Psychiatric Association's "Resource Document on Principles of Informed Consent" 1996 *State Newsletters* which states : "Many states allow psychiatric treatment to occur without patients' informed consent when countervailing policy objectives can thereby be achieved."

advocated policy change concerning compulsory testing for HIV antibodies is unlikely to occur for the time being, whatever its merits might be from a medical point of view.

The physician's degree of disclosure is affected by a multitude of variables, which allow for exceptions to the general rule of disclosure. Thus, in South African law, emergency, unconscious condition (the doctrine of *negotiorum gestio*), waiver and therapeutic privilege are recognised exceptions to the general disclosure rule.[35] Where the therapeutic privilege is invoked beneficence-based considerations of the welfare of patients are allowed to override the patient's right to authorise or refuse medical care or, at least, to compete with it successfully in exceptional circumstances. But respect for autonomy has thereby not been abandoned in law as the justificatory basis of the patient's right of self-determination. It is merely circumscribed in view of the doctor's dilemma referred to above. The dilemma facing the doctor is said to have led to the limited acceptance of the so-called therapeutic privilege in law. The underlying principle, the right of the patient to decide what, if anything, should be done with or to his body is not subverted thereby. Informed consent and its flip side, informed refusal, as a process of two-way communication between client and health-care provider, and "a process of disclosure, information sharing and deliberation"[36] is not abandoned; it is just modified in view of the doctor's dilemma which the law recognises as a real one, calling for a pragmatic, undogmatic or realistic approach to legal issues affecting the professional liability of doctors.

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35 See Claassen & Verschoor *Medical Negligence in South Africa* (1992) 69 *et seq.* The APA Resource Document 1996 *op cit* - note 24 - provides the following categories of exceptions to the disclosure requirements : emergency, waiver, therapeutic privilege, incompetence and involuntary treatment.

36 The American Society for Gastrointestinal Endoscopy (ASGE) *Risk Management : An Information Resource Manual* (Internet). This "process" is one of "complete and candid communication", according to Katz "The Doctor's Dilemma : Duty and Risk in the Treatment of Jehovah's Witnesses" 1996 *SALJ* 484.

"The concept of informed consent is based on the ethical concept of self-determination or autonomy", as the Information Resource Manual prepared by the American Society for Gastrointestinal Endoscopy (ASGE) puts it, therefore doctors will always "have not only an ethical and moral duty to obtain informed consent prior to procedure, but a legal one as well."[37] The ASGE Manual also remarks candidly that the "process of informed consent is an excellent risk management technique", with two major advantages for the doctor attached to it: (1) It offers an excellent opportunity to communicate with the patient. "Trust and mutual respect develop. Remember, if the patient likes you, he is less likely to sue you. (2) During the disclosure process of informed consent, you effectively shift the risk and burden of potential complications to the patient-consumer. Once the patient bears the risks, you indemnify yourself against liability arising from realized complications." Within the framework of the process of informed consent the doctor's therapeutic privilege is an additional defence available to the doctor which, if invoked, must be proved. That is its "true analysis" according to Lord Scarman in *Sidaway v Bethlem Royal Hospital Governors.*[38] He attributes the introduction of this defence into the law of informed consent to the existence of the prudent patient test, the prudent patient being a norm, not a real person. He argues : "Hence there is a need that the doctor should have the opportunity of proving that he reasonably believed that disclosure of the risk would be damaging to his patient or contrary to his best interest. This is what the Americans call the doctor's 'therapeutic privilege'".[39]

The American Psychiatric Association in its 1996 Resource Document on Principles of Informed Consent lists five categories of exceptions to disclosure requirements, therapeutic privilege being one of them. The Document states : "Some jurisdictions permit information to be withheld when disclosure *per se* would be likely to cause harm to patients (e.g., when a patient with an unstable

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37 *Op cit* - note 36.

38 [1985] 1 All ER 635 (HL) at 654.

39 *Ibid.*

cardiac arrhythmia would have his or her situation exacerbated by the anxiety attendant on full disclosure of the risks of treatment). The harm cannot result from patients' decisions not to receive the proposed treatment. This exception must be construed narrowly lest it undermine the general principle of informed consent."[40]

As an analysis of the law of fifty American states has shown, the notion of a therapeutic privilege is equally common in jurisdictions with professional (doctor-determined) standards of disclosure as in those which adhere to an objective patient-based test, except that in the latter jurisdictions the notions about the therapeutic privilege of medical professionals are stricter and less generous than in the former.[41] This is not surprising, since "the wider the parameters of informed consent are defined, the narrower becomes the scope of the privilege"[42] and *vice versa*.

The recognition of a defence of this nature in South Africa recently has attracted critical comment on the grounds that it makes "serious inroads upon the patient's fundamental rights relating to autonomy and self-determination",[43] since its invocation sanctions a professional discretion to withhold information. But then "the doctor's legal duty of disclosure to the patient is a relative one only"[44] after all. In determining the scope of the doctor's duty to disclose two values must be taken into consideration, "namely the duty of the doctor to act in what he conceives to be in the best interests of the patient and the right of the patient to control his own life and to have the information necessary to do so", as King CJ

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40 *Op cit.* - note 24.

41 See Giesen *MML* 377.

42 Van den Heever *op cit* - note 6 at 434.

43 *Ibid.*

44 Strauss *Doctor* 15.

observed in the Australian case *F v R*[45] which observation was quoted with approval by Ackermann J in *Castell v Greef.*[46]

As a unified doctrine, which comprises the requirements of disclosure and consent and the legally recognised exceptions, the doctrine of informed consent is able to accommodate both values, balancing them depending upon the facts and circumstances of the particular case.[47] Consequently, no "firm and inflexible balance is to be found in the law of informed consent"[48] as it stands in North America as well as in South Africa today. In other words : "The doctrine subordinates the societal concern with health to individualism, but not in any fixed proportion."[49] The legal and ethical consensus on the right of individuals that has developed over the past twenty years is therefore in no way endangered by the recognition of the therapeutic-privilege defence. It is rather enhanced thereby .

2.3 Ethical Aspects of Informed Consent and Therapeutic Privilege

The last two decades of the 20th century have witnessed an increased interest in the ethical dimensions of health care which is thought to be part of "an explosion of interest in the ethical dimensions of various aspects of society" in general typical of "the ethics era" within this century.[50] The American Medical Association's official policy on informed consent, published in 1981, in particular, closely copying the language of *Canterbury v Spence*,[51] the landmark American

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45 (1983) SASR 189 at 191.

46 *Supra* - note 4 at 423.

47 See Meisel *op cit* - note 29 at 434.

48 *Ibid.*

49 *Ibid.* See also Williams *op cit* - note 30 at 261.

50 Williams *op cit* - note 30 at 255.

51 464 F 2d 772 (DC App 1972).

decision of 1971, is "a testament to the impact of the law of informed consent on medical ethics".[52]

Ethics in this context means "the study of morality, of the good and the bad, the right and the wrong in human decision making and behaviour"[53] in the wider sense. Bioethics on the other hand refers to "the moral issues and problems that have arisen as a result of modern medicine and research"[54] and the rapid diffusion of modern medical technology in particular. The ethical problems that arise when this technology is used provide the substance of bioethical reflection and action.

Medical ethics is a subdivision of this field of study and practice. Most of the work done in this area has up to now reflected a monocultural perspective on both health care and ethics, with the competent, rational individual adult as the norm for ethical decision-making.[55] Each individual's decision to make use of medical advances rationally was therefore seen as "the biggest medical ethical choice of all".[56] However, in recent years there has been a growing recognition

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52 Faden & Beauchamp *op cit* - note 21 at 98.

53 William *op cit* - note 30 at 256.

54 Lewis & Tamparo *op cit* - note 25 at 8. The formulation of the Nuremberg Code in the Nuremberg Medical Trial of Nazi doctors which began on December 9, 1946 was "the beginning of the modern effort to ensure conduct in research" according to Moreno "Reassessing the Influence of the Nuremberg Code on American Medical Ethics" 1997 *Journal of Contemporary Health, Law and Policy* 347. As the Holocaust and Hiroshima mark the beginning of the postmodern world this effort should more appropriately be characterised as "postmodern", however. "The 'double discourse' of the postmodern world is both illustrated and illuminated in our post-World War II discourse on human experimentation; a discourse that simultaneously condemns the Nazi experiments as barbaric, while demanding access to contemporary experiments as a human right", according to Annas "Questing for Grails : Duplicity, Betrayal and Self-Deception in Post-modern Medical Research" 1996 *Journal of Contemporary Health Law and Policy* 299.

55 See Williams *op cit* - note 30 at 260. The United States judges who formulated the Nuremberg Code adhered to a natural law theory. It was derived from universal moral, ethical and legal concepts and intended for universal application. See Annas *op cit* - note 54 301.

56 Chuang & Man "Medical Ethics - Informed Consent - Ethical Considerations" 1983 *Med Law* 25.

that the dominant North American approach to bioethics with its emphasis on the autonomous individual in medical decision-making is in fact "a minority position within the global community"[57] and must be treated as such, when considering the twin issues of disclosure standards and non-disclosure privileges.

Informed consent and telling the truth to terminally ill patients are two of the major recurrent ethical issues in contemporary health care. The concept of communicative action highlights two aspects of the process of informed consent: "the teleological one of implementing an action plan and the communicative one of arriving at a shared interpretation of the situation, or more generally, of reaching consensus."[58] The procedure of discursive decision-making aims at reaching agreement as a mechanism for coordinating actions: "The kind of agreement that is the goal of efforts to reach understanding depends on rationally motivated approval of the substance of an utterance",[59] however.

It cannot be brought about by manipulating one's partner in interaction, as far as discourse ethics is concerned. Thus, for instance, the assumption that the deception involved in administering placebos (the use of pharmacologically inactive substances) is justified in the interests of the patient's well-being, could be challenged from a discourse ethical point of view, since the use of placebos involves misrepresentation either as to the patient's condition or the nature of the cure.[60]

It is a basic moral principle of our society that one should tell the truth. This

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57 Williams *op cit* - note 30 at 261.

58 Habermas *Moral Consciousness and Communicative Action* (1990) 134 *et seq.*

59 *Ibid* 134. Or as the Nuremberg Code formulates : "The voluntary consent of the human subject is absolutely essential. This means that the person involved .... should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision", as the Nuremberg Code puts it according to Annas *op cit* - note 54 303 n 13.

60 See Giesen *MML* 383.

principle is subject to exceptions, however, since there are circumstances in which withholding the truth or even telling a lie is justified by our moral intuitions. These are intuitions "that instruct us on how best to behave in situations where it is in our power to counteract the extreme vulnerability of others by being thoughtful and considerate."[61] Under certain conditions "it is right (or good in the moral sense) to lie"[62] and not right or bad in the moral sense to tell the truth.

These conditions may be given where disclosure of the truth would endanger the patient's life or health or therapy. This raises the controversial issue whether or not a patient may in certain circumstances be told a lie. This problem arises in cases of solicited information in particular. One could argue that a deliberate lie in response to a specific question from the patient constitutes evidence of bad faith vitiating the patient's consent altogether.[63] Here the therapeutic-privilege argument would have to be used "that disclosure of the information would have been harmful to the patient and, accordingly, the lie was in the patient's best interests"[64] to ward off the threat of non-disclosure liability, of course. The court would probably accept this argument in the case of a terminal cancer patient, since even in court telling the truth is not an absolute obligation, as Türkel J remarked, adding that in his opinion "in the majority of cases, it is our duty to lie to the terminal cancer patient and in any case, he/she shall not be told the whole truth except of what is of vital importance and most necessary, for example, as for purposes of medial treatment".[65] Especially where a child patient is concerned "revealing the truth" would, in his view, be tantamount to committing "an incomparable inhuman

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61 Habermans *op cit* - note 58 at 199.

62 *Ibid* 53.

63 See Jones *op cit* - note 18 at 215.

64 *Ibid.*

65 Türkel "Remarks on Telling the Truth or Lying" 1985 *Med Law* 92.

act".[66]

The moral intuition underlying this argumentation can be conceptualised as the humanitarian principle in terms of which the doctor's duty to disclose is subject to a number of "Kontraindikationen" or counterindications.[67] These exceptions are indicated in the interest of the patient's psychological well-being, of urgently required treatment or in order to avert harm from third persons. In ethical terms, this means that the postulate of non-deception is modified by the principle of *nil nocere*.[68]

The idea justifying deception in this instance is to assist and support the patient instead of harming him by full disclosure. What is administered here is, in other words, "the drug named illusion".[69] Its use is justified by the arguments (also employed as objections against the informed-consent doctrine in other instances) "that truth-telling may be contrary to the patient's own best interest; and that disclosure of an unfavourable or adverse diagnosis or prognosis may have a harmful effect on the patient and therapy".[70]

The invocation of the humanitarian principle in exceptional cases in no ways intrudes upon or diminishes the ideal of informed consent. On the contrary, it affirms that ideal, but not in terms that are so absolute or unqualified as to be unrealistic[71] or inhuman. The humanitarian principle undermines the rigid monoculturalism of bioethics, reminding us in the process that in "many cultures medical paternalism is the morally correct way to make treatment decisions, and

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66 *Ibid* 93.

67 Deutsch *Arztrecht* 2nd ed (1991) 70.

68 *Ibid.*

69 Türkel *op cit* - note 65 at 92.

70 Van Oosten *Med Law* 33.

71 Strauss *Doctor* 18.

other approaches are simply wrong".[72] It is of course true that hard cases make bad law, and the violation of the principles of informed consent in general remains a disreputable practice of medicine. But, nevertheless, ethically sound procedures must be promoted to deal with such hard cases. Having recourse to the humanitarian principle may be one of them.

2.4 CLINICAL ASPECTS OF INFORMED CONSENT AND THERAPEUTIC PRIVILEGE

The dimensions of informed consent established by law are augmented in several ways suggested by clinical experience. This is "consistent with the physician's ethical obligation to respect patients' autonomy and to promote their well being",[73] as the 1996 Resource Document of the American Psychiatric Association points out. It is also in keeping with the ultimate aim of bioethics which is to determine what ought to be done for patients, their physical and/or mental condition being an important factor in this process.[74] The patient's ability to understand information relevant to a decision and to appreciate the reasonably foreseeable consequences of a decision, in short, his or her decision-making capacity, is of primary importance in this context, since capacity is an essential component of valid consent.[75] In law, capable patients (that is patients with decision-making capacity) are entitled to make their own informed decisions.

This is in accordance with the ethical principles of patient autonomy and respect

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72 Williams *op cit* - note 30 at 262.

73 APS Resource Document *op cit* - note 34.

74 See Williams *op cit* - note 30 at 265.

75 See Etchells *et al* "Bioethics for Clinicians : 2. Disclosure" 1996 *Canadian Medical Association Journal* 389.

for persons.[76] If a patient is incapable of making an informed decision, consent must be obtained from a proxy decision-maker to secure substitute consent. This is in line with the ethical principle of beneficence which requires that the incapable persons be protected from making decisions harmful to them or which they otherwise would not have made. Where capacity cannot be reasonably presumed, a capacity assessment is called for.[77] Incapacity to make medical decisions is not the same as a legal determination of incompetence which only a court can make.

Capacity determinations are left to the medical or mental health professions.[78] It thus is the responsibility of the medical profession to determine the patient's capacity to consent. When capacity is impaired it is the task of the medical team to take appropriate measures such as seeking proxy consent.[79] Refusal of treatment as such does not constitute evidence of incapacity. Agreement or disagreement with the patient's decision is not an issue here. The sole purpose of capacity assessment is an evaluation of the person's ability to understand the relevant information and to appreciate the consequences of making a decision.[80] Similarly, the patients' reasons for a decision are irrelevant here as long as a decision is not based substantially on delusions or depression, in which case psychiatric evaluation may be indicated.[81]

Capacity assessment concerns the incapable patient. However, the legally required disclosure in terms of the doctrine of informed consent creates

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76 See Berg "Legal and Ethical Complexities of Consent with Cognitively Impaired Research Subjects : Proposed Guidelines" 1996 *Journal of Law, Medicine and Ethics* 26.

77 See Etchells *op cit* - note 75 at 388.

78 See Berg *op cit* - note 76 at 30 n 6.

79 *Ibid* 25.

80 See Etchells *op cit* - note 75 at 388.

81 See Katz "The Doctor's Dilemma : Duty and Risk in the Treatment of Jehovah's Witnesses" 1996 *SALJ* 493.

problems in the case of perfectly capable patients as well. There is a growing recognition that the disclosure required by law is in many - if not most - cases beyond the capacity of the ordinary person to such an extent that it threatens to impede rather than promote patient decision-making and thus might become self-defeating or counterproductive in the long run.[82] It has been argued that this development is the net result of the view taken by many jurisdictions adopting the informed consent doctrine that the decision as to risk disclosure is a legal question, and not a medical question.[83] This in turn means that it is left to lay persons to express what amounts in essence to medical opinion.

This argument[84] implies a call for the return to the professional standard as opposed to the patient-based or lay standard, of course, and advocates a reversal of the modern-trend disclosure rule which is problematic indeed, even from a clinical point of view. For it is thought that it is generally desirable for patients to be given as much information as they can assimilate, even though they may be incapable of grasping all of it, as this practice facilitates physician-patient collaboration in treatment.[85]

On the other hand it is an undeniable fact that unrealistic disclosure requirements may result in a surrogate liability incurred by the doctor's inability to adhere to them and in an expansion of the liability of the medical profession with the doctrine of informed consent as its legal mechanism.[86]

While this may not be a deliberate judicial policy, the courts in America and

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82 See Weissauer "Grenzen der Eingriffsaufklärung" in Laufs *et al* (eds) *Artzhaftung* (1997) 18 and 23. "Over-informing" a patient may be tantamount to not informing the patient at all. Strauss *Doctor* 12.

83 See Weissauer *op cit* - note 82 at 24.

84 See *Hook v Rothstein* 316 SE 3d 690 (SC App 1984) at 697.

85 See APS Resource Document *op cit* - note 34; Etchells *op cit* - note 75 at 388.

86 See Weissauer *op cit* - note 82 at 23; Robertson "Informed Consent to Medical Treatment" 1981 *LQR* 112.

elsewhere have tended to overlook the question of patient comprehension and to focus instead on the physician's obligation to disclose information,[87] losing sight of the clinical realities of the doctor-patient relationship in the process at times.

3. JUDICIAL FORMULATIONS OF THE PRIVILEGE

3.1 Introduction

Of all the exceptions that may narrow the scope of disclosure, therapeutic privilege is the most frequently discussed, though only few cases turn on its application.[88] This situation prevails in Common Law and at Civil Law jurisdictions alike, with judicial lip-service being paid to a concept that in social reality does not feature prominently at all.[89] This concept has been formulated by legislatures and courts in various ways. Its formulations range from the rather vague to the more specific, as will become apparent from the following survey. The parameters of the exception are as yet undefined in American and other legal systems alike.[90]

3.2 American Law

It is well established in American case law and commentary that there are situations where the doctor may be excused from compliance with the informed-consent requisite by the therapeutic privilege defence which allows for the withholding of information in circumstances where full disclosure from a medical

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87 See Robertson *op cit* - note 86 at 112.

88 See Meisel *op cit* - note 29 at 460.

89 See Giesen *MML* 380 *et seq.*

90 See Strauss *Doctor* 18 *et seq.*

point of view is considered unsound or harmful.[91] Two leading informed consent cases are *Canterbury v Spence* and *Cobbs v Grant*.[92] Disclosure standards differ from Alabama to Wyoming.[93] The majority rule is the traditional medical community standard, the minority rule being the patient-based legal standard, set out, *inter alia*, in *Cobbs* and *Canterbury*.[94] In *Pauscher v Iowan Methodist Medical Center*[95] the so-called patient-based standard was held to "applicable in all informed consent cases". This standard "makes full disclosure the rule but allows for numerous exceptions which the physician, who has access to the medical knowledge involved, can assert".[96] The question when informed consent is not required remains unresolved, however, as judicial views vary in the interpretation of each of these situations.[97] A number of exceptions to informed consent are peculiar to each state, one being that the "physician may not be responsible for failing to disclose risk(s) when the knowledge might be detrimental to the client's best interest".[98]

The Information Resource Manual of the American Society for Gastrointestinal Endoscopy (ASGE) lists five exceptions to the informed consent process, commenting on the therapeutic privilege exception as follows: "There are times when the disclosure of informed consent might be detrimental to the welfare of certain patients. The law recognizes this and has fashioned the exception of

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91 See Etchells *op cit* - note 75 at 388; Meisel *op cit* - note 29 at 460; Robertson *op cit* - note 86 at 120.

92 See Strauss *Doctor* 18; Giesen "From Paternalism to Self-Determination to Shared Decision Making" 1988 *Law Med* 122.

93 See ASGE Resource Manual *op cit* - note 36.

94 See Johnson "An Overview of Informed Consent : Majority and Minority Rules" in James (ed) *Legal Medicine with Special Reference to Diagnostic Imaging* (1980) 287.

95 408 NW 2d 355 (Iowa 1987) at 359.

96 *Ibid* at 360.

97 See Chuang & Man *op cit* - note 56 at 21.

98 Lewis & Tamparo *op cit* - note 25 at 100.

therapeutic privilege. If you believe that the informed consent disclosure would, on balance, be more harmful to a patient, you may delete it citing the exception. In reality, the law looks with a critical eye towards the use of therapeutic privilege ....".[99]

This commentary follows the *Canterbury* formulation of the extent of the therapeutic privilege closely in terms of which this "exception obtains when risk-disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view".[100] This is the court's most general statement of the privilege, however. It also provided a more stringent formulation framed in terms of the primary functions of the informed consent doctrine, namely "to promote patient primacy in medical decision-making" (1) and "rational decision-making" (2).[101] The court therefore insisted that the "physician's privilege to withhold information must be carefully circumscribed, however, for otherwise it might devour the disclosure rule itself".[102]

This privilege therefore constitutes a circumscribed exception to the general disclosure rule which does not embrace "the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs".[103] It furthermore does only contemplate operation "where the patient's reaction to risk information, as reasonably foreseen by the physician, is menacing";[104] and even then "disclosure to a close relative with a view to securing consent to the

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99 *Op cit* - note 36.

100 *Canterbury v Spence Supra per* Robinson CJ at 789.

101 Meisel op cit - note 29 at 462 n 158.

102 *Canterbury supra* at 789.

103 *Ibid.*

104 *Ibid.*

proposed treatment may be the only alternative open to the physician",[105] the court added, thus upholding the "foundational principle that the patient should and ordinarily can make the choice for himself",[106] and its correlative, proxy consent.

The concept of therapeutic privilege as framed in *Canterbury* goes to psychological harm only,[107] but other American cases and texts take up the notion of psychological or physical harm, thus broadening the definition considerably.[108] Consequently therapeutic privilege has been accepted in regard to intravenous pyelogram or IVP cases in some American jurisdictions as well, where physical harm to the patient is the issue and not psychological detriment.[109]

Cases of that nature involve the doctrine of informed consent and are deemed to sound in negligence.[110] Quoting *Salgo v Leland Standford Jr University of Trustees*[111] with approval the court in *Nishi v Hartwell*[112] held that the doctrine of informed consent recognises "that a physician may withhold disclosure of information regarding any untoward consequences of a treatment where full disclosure will be detrimental to the patient's total care and best interest".

The *Nishi* court subscribed to the view expressed in *Watson v Clutts* that it may

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105 *Ibid*; see Fennell *Treatment without Consent* (1996) 337.

106 *Canterbury v Spence supra* at 189.

107 See *Meyer Estate v Rogers* (1991) 78 DLR 4th 307 per Maloney J at 313.

108 *Ibid.*

109 *Ibid* at 308. The IVP test involves an intravenous injection of a contrast medium for a radiologic procedure.

110 See *Nishi v Hartwell 473* P 2d 11 (Hawaii 1970) at 118 *et seq.*

111 *Salgo* H 317 P 2d 170 (Cal App 1957).

112 *Supra* at 119. See Fennell *op cit* - note 105 at 237 *et seq.*.

be difficult "to state any hard and fast rules as to the extent of the disclosure required"[113] and accepted the argument that the "doctor's primary duty is to do what is best for the patient" which means in turn: "Any conflict between this duty and that of a frightening disclosure ordinarily should be resolved in favour of the primary duty."[114] In the *Nishi* case the court adopted the view that the question of negligence in a medical malpractice action is to be decided "by reference to relevant medical standards"[115] to be proved by the plaintiff as being applicable. The only medical standard established in this case was the defendants' own testimony which the court "deemed to be expert medical testimony"[116] sufficient to justify the defendant-doctors' omission to disclose even under the minority rule.[117] But the court did not go into the respective merits of the prevailing majority rule and the minority rule, deeming this unnecessary under the circumstances.

The standard adopted by the *Nishi* court has been criticised as being "antithetical to individualistic values",[118] however, because it does not take into account the patient's ability to participate in medical decision-making at all. It was vindicated nevertheless in another IVP case were an action was brought against a radiologist for wrongful death of a patient allegedly caused by the radiologist's failure to inform the patient of the potential fatal risk involved in the IVP procedure.[119] The court, on the other hand, supported the view adopted in the *Canterbury* case that "the therapeutic privilege does not allow a physician

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113 *Supra*.

114 *Ibid*. See Mulvaney "The Therapeutic Privilege" 1996 *Medical Trial Technique Quarterly* 77.

115 *Nishi supra* at 121. See Mulvaney *op cit* - note 114 *et seq* on the standards of disclosure adopted by American Courts.

116 *Supra* at 123.

117 *Ibid*.

118 Meisel *op cit* - note 29 at 463.

119 *Hook v Rothstein supra* at 693.

to withhold risk information because the physician feels the information might prompt the patient to forego treatment".[120] There may well be other American IVP cases involving wrongful death allegations where the doctor's non-disclosure was excused on the basis of therapeutic privilege in similar vein.[121] But, as far as is known, not in Canada.

3.3 Canadian Law

The legal status of therapeutic privilege in Canada is uncertain. The IVP case of *Meyer Estate v Rogers*[122] involving a patient who died after intravenous injection of a contrast medium for a routine radiologic procedure, makes this abundantly clear. The radiologist claimed therapeutic privilege as a defence against his alleged failure to warn the patient of the risks of intravenous dye injection. The court, in rejecting the defence on the grounds that therapeutic privilege was not applicable, held that "the Supreme Court of Canada has not, in *Reibl*, adopted or even approved the therapeutic privilege exception in Canada", and concluded that the "instant case may well be the first one in Canada where that issue falls squarely to be determined".[123]

In *Reibl v Hughes*[124] the court alluded to the privilege by commenting "that a particular patient may, because of emotional factors, be unable to cope with facts relevant to recommend surgery or treatment and the doctor may, in such a case, be justified in withholding or generalizing information as to which he

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120 *Supra* at 704.

121 *Meyer Estate v Rogers supra* at 314. See *Arato v Avedon* 858 P 2d 598 (cal 1993) where the physicians were relying on the defence of therapeutic privilege, but where the court did not have to decide on the basis thereof. Mulvaney *op cit* - note 114 at 83 nevertheless feels that "*Arato* is a strong case for the use of therapeutic privilege" in principle.

122 *Supra* at 314.

123 *Ibid.*

124 (1980) 114 DLR 3rd 1 at 13.

would otherwise be required to be more specific". This comment is an *obiter dictum.* The therapeutic privilege exception was raised and summarily dismissed in *Haughian v Pain*[125] with the court remarking: "There is no suggestion here that the respondent withheld the information because of 'therapeutic privilege'. There was no suggestion that disclosure would have unduly frightened the appellant, caused him psychological harm or deterred him from taking treatment essential to his health. The respondent's position was simply that it was not his practice to warn of this risk". Maloney J in *Meyer Estate v Rogers*[126] was not only of the opinion "that the therapeutic privilege exception does not form part of the law of Canada", but also expressed the view "that it should not become part" thereof. He gave two reasons for this, namely (1) what he considered "an unwarranted extension of the privilege beyond its original scope which protected patients only from potential psychological harm" in the United States, and (2) the potential of the privilege "to override the requirement for informed consent" and to swallow the disclosure rule altogether.[127]

Although therapeutic privilege is in fact practised in Canada (for example in giving placebos to hypochondriacs), its scope is said to be far more limited than previously.[128] In view of the uncertain legal status of therapeutic privilege clinicians in Canada are advised against invoking it. It is said to be better "to offer information and allow the patient to refuse or accept further disclosure"[129] for several reasons. Such a practice is (1) in keeping with the ethical principles of patient autonomy and respect for persons, (2) it promotes patients' informed participation in health-care decisions, and (3) also promotes a trusting

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125 (1987) 37 DLR 4th 624 at 644.

126 *Supra* at 316.

127 *Ibid.*

128 See Williams *op cit* note 30 at 263.

129 Etchells *op cit* - note 75 at 389.

relationship between patient and health-care provider.[130]

3.4 Anglo-Australian Law

The English courts do not recognise the doctrine of informed consent.[131] Consequently, in the absence of a general duty of disclosure, no recognition has been given to therapeutic privilege as a restriction to the informed-consent requisite either.

The English courts deal with such cases on the basis of the patient's best interests principle instead.[132] The notion of "therapeutic privilege is thus not a defence in a non-disclosure case, but is incorporated within the duty of disclosure itself, in line with *Sidaway v Bethlem Royal Hospital Governors*.[133] This means that where "the medical evidence indicates that the normal practice of the profession is to disclose a particular risk, it will be for the defendant to justify non-disclosure to the patient".[134] Scarman LJ in *Sidaway*[135] described the scope of the therapeutic privilege as follows: "This exception enables a doctor to withhold from his patient information as to risk if it can be shown that a reasonable assessment of the patient would have indicated to the doctor that disclosure would have posed a serious threat of psychological detriment to the patient".

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130 *Ibid* 388.

131 See Strauss *Handbook* 13; Strauss "Privaatheidskending en die Toestemmingsvereiste by Bloedtoetsing vir Vigs" 1996 *THRHR* 492.

132 See Van Oosten *Consent* 403; Robertson *op cit* - noted 86 at 126; *Rogers v Whitaker* (1993) 67 ALJR at 50; Fennell *op cit* - note 33 at 243.

133 [1985] 1 All ER 635 (HL); see Jones *op cit* - note 18 at 244.

134 Jones *op cit* - note 18 at 244. See Fennell *op cit* - note 33 at 235.

135 *Supra* at 653.

In *Lee v South West Thames Regional Health Authority*[136] it was suggested that the doctor's duty to answer a patient's question must be "subject to the exercise of clinical judgement as to the terms in which the information is given and the extent to which, in the patient's interests, information be withheld". The best interests of the patient principle referred to in this statement has been criticised as an example of paternalism overriding the patient's right to self determination.[137]

In *Hatcher v Black*[138] the matter was taken a step further. The court held that a doctor may even tell a lie if he considers this to be in the patient's best interests. It seems, however, that the judicially sanctioned white lie is precluded by the comment made by Bridge LJ in *Sidaway*[139] that the doctor's duty must be "to answer both truthfully and as fully as the questioner requires" when questioned specifically by a patient.

In Australia the professional standard or the *Bolam* principles has been discarded.[140] Instead the courts have adopted a patient oriented standard.[141] Two leading decisions of the Australian courts on the standards of disclosure required of a doctor in treating a patient are *F v R* and *Rogers v Whitaker.*[142] King CJ in *F v R* accepted that "there may be circumstances in which

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136 [1985] 2 All ER 385 at 389.

137 See Robertson *op cit* - note 8 at 121; Fennell *op cit* - note 33 at 246.

138 *The Times* July 2 1954 as cited by Jones *op cit* - note 18 at 247 and Claassen & Verschoor *op cit* - note 35 at 70.

139 *Supra* at 661.

140 The so-called reasonable doctor standard of disclosure as enunciated in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 leaves the entire question of the duty of disclosure, including the question whether there has been a breach of that duty, to the medical profession. It is also referred to as the *Bolam* principle. See also Jones *op cit* - note 18 at 244.

141 *F v R* (1983) 33 SASR 189 at 193; see *Rogers v Whitaker supra* at 51; Fennell *op cit* - note 33 at 234.

142 *Supra.*

reasonable care for the patient may justify or even require an evasive or less than fully candid answer even to a direct request".[143] This approach is similar to that subsequently adopted by Scarman LJ in *Sidaway*[144] and has been followed in later cases as well.[145] King CJ specified two situations in particular in which a doctor is justified in withholding information and refraining from volunteering information, namely (1) "when he judges on reasonable grounds that the patient's health, physical or mental, might be seriously harmed by the information", and (2) when the doctor reasonably judges that a patient's temperament or emotional state is such that he would be unable to make the information a basis for a rational decision".[146] King CJ adhered to this in the later case of *Battersby v Tottman*,[147] where these considerations were applied to the facts. The court in *Rogers v Whitaker*[148] fully agreed with the views expressed by King CJ in *F v R*.[149]

3.5 German Law

In German law the notion of therapeutic privilege is accepted in terms of contra-indications to the duty to inform, but within narrow limitations only.[150] The German courts recognise a defence of therapeutic privilege which allows doctors to manipulate the amount of information given to patients in exceptional cases.[151] The German Federal Supreme Court has not excluded the possibility

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143 *Supra* at 192.

144 *Supra*.

145 See *Rogers v Whitaker supra* at 51.

146 *Supra* at 193.

147 (1985) 37 SASR 524 at 527.

148 *Supra* at 52..

149 *Supra*.

150 See Strauss *Doctor* at 19.

151 See Shaw "Informed Consent : A German Lesson" 1986 *ICLQ* 877.

that objective reasons may justify a reduction of the scope of disclosure required as a rule, but has strongly objected to the notion of therapeutic privilege as such.[152] It has only "allowed therapeutic reasons which may *narrow* rather than *negative* disclosure to the patient".[153] Therapeutic reasons for narrowing the scope if disclosure are legally only acceptable in very rare circumstances and must be very narrowly construed accordingly. Otherwise the patient's general right to know might be undermined inadvertently or deliberately.[154]

This right is firmly entrenched in German law as a result of a decision of the Imperial Court in 1894 which ruled that medical treatment without consent constituted assault or *Körperverletzung*. The controversy created by this legal construction was finally settled by a decision of the Federal Constitutional Court in 1979 concerning the professional liability of medical doctors and the fundamental principle of patient autonomy.[155] The Federal Supreme Court has recognised restrictions to the duty of disclosure only where disclosure would cause the patient serious physical or psychological harm or even death,[156] or would detrimentally affect his or her health or therapy.[157]

The Federal Supreme Court held that where a detailed disclosure was contraindicated because it would cause "serious and irreversible damage of the patient's health" non-disclosure might be justifiable,[158] whilst proxy consent

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152 See Giesen *MML* 381; Steffen *Neue Entwicklungslinien der BGH-Rechtsprechung zum Arzthaftungsrecht* 6th ed 148; Pelz "Verschulden - Realität and Fiktion" in Laufs *et al* (eds) *Die Entwicklung der Arzthaftung* (1997) 54.

153 Giesen *MML* 381.

154 *Ibid.*

155 See Weissauer *op cit* - note 82 at 18 *et seq.*

156 Laufs & Uhlenbruck *Handbuch des Arztrechts* (1992) para 64.

157 Soergel *Kommentar zum Bürgerlichen Gesetzbuch* 12th ed (1987) para 823; Laufs *Arztrecht* 5th ed (1993) 387 and 381.

158 Giesen *MML* 385.

should be sought from friends or relatives.[159] This formulation has been criticised as being very strict and narrowminded (*engherzig*), however.[160]

The Federal Supreme Court has furthermore recognised, in the context of psychiatry and psychotherapy, that the scope of disclosure may be narrowed where the interests of third parties such as family and friends who have testified against the patient must be safeguarded.[161]

The German courts try to strike a balance between the patient's right to self-determination and the doctor's capacity to adhere to the strict disclosure requirements realistically. With this purpose in mind the courts have allowed for exceptions to the general disclosure rule, but construed these very narrowly in view of the overriding principle of patient autonomy which is firmly established in German case law and in the German Basic Law alike, which in article 2 entrenches the right to bodily integrity and self-determination.[162]

4. CONCLUSION

The duty to disclose is not absolute, but relative. On this there is general agreement. Various instances can be identified in which the duty of disclosure is restricted or does not exist at all. These exceptions to the general disclosure rule have been conveniently categorised in the form of instances where the defence of therapeutic privilege is applicable in certain jurisdictions.[163] These

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159 Soergel *op cit* - note 157 at 823; Palandt *Bürgerliches Gesetzbuch : Kommentar* 56 ed (1997) para 823.

160 Laufs & Uhlenbruck *op cit* - note 156 at para 64; Laufs *op cit* - note 157 at 107; Deutsch *op cit* - note 67 at 71. The Council of Europe Draft Bioethics Convention (1994) refers to "serious harm" only. Irreversibility is not required there; see Fennell *op cit* - note 33 at 293.

161 See Giesen *MML* 382; Deutsch *op cit* - note 67 at 72.

162 See Weissauer *op cit* - note 82 at 17 *et seq*; Soergel *op cit* - note 157 at para 823.

163 See Van Oosten *Consent* 32 *et seq.*

are the following:

(1) Where disclosure would be detrimental to the patient's health (physical or mental) or endanger his or her life.
(2) Where it might interfere with the patient's rational decision-making.
(3) Where it might detrimentally affect the patient's therapy.
(4) Where it would be inhuman.
(5) Where the risks attached to it are as grave as those attached to the treatment or even outweigh them.
(6) Where it will present a threat to a third party.

The following cases illustrate some of the instances where the defence of therapeutic privilege might be applicable in the context of disclosure and patient consent. These cases are hypothetical. They do, however, reflect case law and factual information obtained from a variety of sources, including informal discussions with clinicians and medical practitioners.

Instances (1) and (2)

Mr A is 92 years old and lives at home on his own. He is a retired psychoanalyst. He undergoes a sudden change in his mental state that is characterised by confusion and disorientation. He runs away from home and is hospitalised, suffering *inter alia* from delusions. He is diagnosed with a type of delirium that affects the elderly, a condition that is reversible if certain drugs are administered. Mr A is kept in the dark about his condition because the doctor fears that Mr A would not submit to such treatment, and even more importantly, might commit suicide on disclosure of his condition due to hurt feelings and professional pride. Antipsychotic drugs are therefore administered without the patient's knowledge. Mr A is able to return home where he resumes his normal life while the treatment continues under false pretences with the family doctor

administering the drugs. Mr A's relatives are, however, fully informed and have consented on his behalf.

Instance (3)

Mr N, a retired dentist, has to undergo a diagnostic surgical procedure to determine the existence of aortic aneurism, that is a bulge or dilation in the wall of an artery, here the aorta. The procedure involves the injection of a radio-opaque contrast medium known to cause serious side effects in some patients, including paralysis from the waist down. Mr N is a well-educated person, but he is also very frightened and apprehensive about his condition. The doctors feel that the disclosure of the collateral hazards involved in the procedure would unnecessarily frighten the patient who suffers from a severe heart condition accompanied by hypertension. They therefore proceed without fully informing the patient of the collateral risks involved in the procedure. The patient ends up paralysed from the waist down.

Mr S, a pensioner, suffers from stomach pains. His family doctor places him on medication and a bland diet. The pains persist and he undergoes an upper and lower gastro-intestinal series of tests. These tests reveal what appears to be a mass of tumour in his lower intestines. It is determined that the next diagnostic step is for Mr S to undergo an intravenous pyelogram (IVP). The radiologist does not inform Mr S about the possibility of a fatal reaction to the contrast medium used in the procedure. The doctor is convinced that patient apprehension plays a significant role in the reaction to the contrast material. He fears that Mr S will undergo the proposed procedure anyway, whether fully informed about the risks involved in it or not, the only difference being that the anxiety resulting from the disclosure of these risks might cause a fatal reaction. Mr S suffers a severe reaction and dies.

A youth troubled by back pain submits to an operation without being informed of a risk of paralysis incidental thereto. The doctor feels that the risk of paralysis is a very slight possibility only. He omits to inform the patient of this risk because in his view such communication might produce adverse psychological reactions which could preclude the success of the operation. A day after the operation the patient falls from his hospital bed. A few hours after the fall, the lower half of his body is paralysed, and he has to undergo another operation. Even years later, he hobbles about on crutches, a victim of paralysis of the bowels and urinary incontinence.

Instance (4)

A famous German writer, Theodor Storm, is told that he suffers from terminal cancer. He is devastated, unable to work and despondent. His doctors convene a meeting and reconsider their findings. But they arrive at the same conclusion as before. They do, however, not reveal the truth to the writer, but tell him that he is not suffering from cancer after all. He settles down to his usual routine and completes a literary masterpiece that makes him one of the great writers of his time.

Doctor R is renowned for his diagnostic acumen and curt truthfulness. For that reason his opinion is highly valued. He is not a mere doctor expressing an opinion, but a judge pronouncing a verdict. Doctor R is called upon to make a house call and subsequent operation on his dearest friend. His friend is very sick, actually dying in the doctor's judgement, and requests a truthful prognosis in order to settle his will. If the doctor reveals his pessimistic opinion that his patient will not survive the night, then this would virtually amount to a death sentence. It would also, in the doctor's view, destroy the thousandth part of a change that the patient had of survival. Dr R does a piece of acting and assures his

friend and patient that he will live. The patient survives indeed.

A middle-aged patient undergoes an operation for the removal of a kidney and is discovered to have a tumour on the tail of the pancreas. The surgeon believes that the entire malignancy is removed, but he nevertheless refers the patient for follow-up therapy to another specialist. There the patient is asked to complete a questionnaire and to answer the question whether he wishes to be told the truth about his condition. The patient states that he wishes to be told the truth. In spite of this request the physician does not disclose the statistical life expectancy information that only two percent of males live for five years after the diagnosis of pancreatic cancer. He feels that the disclosure of extremely high mortality rates for malignancies such as pancreatic cancer might effectively deprive a patient of any hope of cure and become a self-fulfilling prophecy. The treatment appears to be successful. However, after the patient reads a newspaper article stating the life expectancy information of his cancer, he suffers a recurrence and dies.

Instance (5)

A doctor at a public hospital prescribes a prolonged course of a particular drug for a patient suffering from mental illness. The doctor does not warn the patient or the patient's relatives of the risk of damage to the eyes, because he is of the opinion that this would have an adverse effect upon the patient. Mere knowledge of the risk to her vision might be sufficient to give rise to the real risk of hysterical blindness. The patient might also refuse to undergo treatment. Such refusal is likely to result in indeterminate confinement in a mental institution with a high risk of suicide. The patient goes blind.

A patient undergoes a diagnostic intravenous pyelogram or IVP test. The

radiologist does not warn the patient of the risks of severe reaction and even death inherent in the procedure. He does this in accordance with the view shared by his professional association that the risk of informing patients of "low risk" procedures including IVP exceeds the risk of not informing them at all, as the most important factors in the production of contrast media reactions are the patients' fear and apprehension. The patient dies in consequence of an allergic reaction.

The general view is that the doctor's duty to disclose is restricted in circumstances where full disclosure would be more harmful than non-disclosure; and this to such an extent that the doctor might even resort to a white lie in exceptional cases, the only moot point being whether or not such a lie is justifiable where the patient asks questions.[164]

The courts are reluctant, however, to apply the therapeutic privilege in medical malpractice cases, and quite rightly so, some writers say, arguing that the danger of allowing medical paternalism in through the back door vindicates the courts' attitude. It has even been submitted "that the law must discourage the widespread invocation of this privilege by not allowing it as a defence in consent cases".[165] Other are more general in favour of applying this defence, however,[166] taking a less restrictive stance. Thus it has been argued that there is "a definite need for a *legal defence* to non-disclosure in cases where the harm caused by disclosure would outweigh the harm caused by non-disclosure",[167] but the term "therapeutic necessity" would be more appropriate to it. The *Castell*

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164 See Van Oosten "*Castell v De Greef* and the Doctrine of Informed Consent" 1995 *De Jure* 172.

165 Giesen *Law Med* 122.

166 See Giesen *MML* 352 n 515 criticising this approach as favouring doctors in general with Claassen & Verschoor *op cit* - note 35 at 71 agreeing, while Mulvaney *op cit* -note 114 at 65 argued that the privilege is a necessary and important defence in informed-consent cases, but suggests that "the courts need to develop a clearer rule on when and how the defence can be applied".

167 Van Oosten *De Jure* 177.

court's approach to the defence reflects both lines of argument in recognising the need for the defence, but at the same time associating it with medical paternalism, which renders it ambivalent indeed.[168]

There are jurists who feel that the doctrine of therapeutic privilege should be abolished altogether because its invocation invariably reintroduces the professional standard of disclosure.[169] Others maintain that this need not be the case, however, provided the courts adopt rules for its invocation in practice which resolve that problem one way or another.[170]

When all is said and done it remains less than clear whether a real need exists for therapeutic privilege as an exception to the general disclosure rule. Even a stringently formulated privilege is easily undercut by rules concerning its application. Therefore it has been concluded that "there seems to be no valid reason to preserve the privilege, and certainly not one which is loosely defined".[171] Echoing these sentiments Maloney J in *Meyer Estate*[172] remarked: "The danger that the therapeutic privilege poses to self-determination in medical decision-making is so great that we should seriously consider its abolition". Others see the therapeutic privilege simply as a device that "pays lip service to the principles of truth telling and self-determination, while it creates a discretionary exception which is quite capable of swallowing these principles

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168 *Ibid.*

169 See Meisel *op cit* - note 29 at 467 and 431 n 69; Giesen *MML* 385.

170 Fennell *op cit* - note 33 at 292 states that the central issue in Britain and elsewhere today is "the basis on which the right to make one's own treatment decision should be suspended", and submits that "there is a clear need to produce a single coherent legal basis on which peoples' right of treatment decision-making can be removed" (at 293). The guidelines for the application of the privilege formulated by Fennell are in keeping with those provided by Van Oosten. The approach adopted by Fennell is that favoured by the common law and the case law of the European Court of Human Rights with "incapacity as the gatekeeper concept" and "a presumption in favour of capacity" (at 293). See also Strauss *Legal Handbook* 10.

171 Meisel *op cit* 469.

172 *Supra* at 314.

when the doctor decides the occasion requires it",[173] thus taking the debate a step further by raising a moral issue. This issue concerns the difference between what is said and what is done. This difference is morally relevant. My reluctance to agree with this analysis and conclusion concerns the role that intention is supposed to play in all this and the conspiracy theory that taints this argument. After all, much depends on the manner in which the exception is defined and applied. The narrower the definition and the more restricted the application of therapeutic privilege, the more the balance is struck in favour of individualism and the less in favour of the societal interest in health care. The one is the logical converse of the other and there is ample room for choices to be made here, legal, ethical and clinical choices that determine the parameters of the therapeutic privilege and circumscribe its application.

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173 Kennedy *The Unmasking of Medicine* (1981) 87 *et seq.* The concept of "therapeutic research" has the potential of disguising the distinction between interventions that are therapeutic and others that are non-therapeutic and thus may be used " to lower the standards for obtaining informed consent", according to Annas "Questing for Grails : Duplicity, Betrayal and Self-Deception in Postmodern Medical Research" 1996 *Journal of Contemporary Health Law and Policy* 315. Experimentation disguised as therapy has been rejected in a case arising from the Cincinnati Whole Body Radiation Experiment which involved 88 subjects from 1960 to 1971. The court, in a decision that is "most noteworthy for its uniqueness", permitted a lawsuit by the families of the subjects against the researchers. Annas *op cit* 309 n 41. See *In re Cincinnati Radiation Litig* 874 F Supp 796 (SD Ohio 1995).

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TABLE OF CASES

INDEX

SUMMARY

This dissertation examines the nature and scope of the therapeutic privilege defence in non-disclosure cases in the context of the doctor's duty to procure a properly informed consent from this patient and his duty to heal, which sometimes are in conflict. The judicial formulations of the so-called therapeutic privilege are an attempt to resolve this conflict equitably. They raise a number of questions, however. To answer these questions this dissertation (1) examines the different aspects of informed consent, (2) explores the leading formulations of the therapeutic privilege concept, and (3) evaluates the ongoing debate concerning its parameters.

Title of dissertation:

THE PARAMETERS OF THE MEDICAL-THERAPEUTIC PRIVILEGE.

Key Terms:

Medical-therapeutic privilege; Informed consent; Legal aspects; Ethical aspects; Clinical aspects; Judicial formulations; American law; Canadian law; Anglo-Australian law; German law; South African law; Parameters; Instances.