

**THE DOCTRINE OF –THERAPEUTIC  
PRIVILEGE AND ITS PLACE IN ~~THE~~ SOUTH  
AFRICAN~~N-LEGAL-SYSTEM~~**

by

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# **PREFACE**

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The staff at the law library for being considerate and helpful.

**NOVEMBER 2014**

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# **DECLARATION**

I, the undersigned, hereby declare that the work contained in this dissertation is my own original work and has not been previously submitted in its entirety or in part at any University for a degree.

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**NOVEMBER 2014**

# ABSTRACT

Therapeutic privilege is an exception to informed consent and used as a defence when the doctor decides to withhold relevant medical information from the patient, because they are of the opinion that such disclosure could harm the patient. This study explores and provides a critical evaluation of the defence of therapeutic privilege since the boundaries and the practical application in the South African legal system are uncertain, resulting in many gaps in the law that require attention. Thus it is unclear as to when the defence is legally justified.

A comparative investigation is undertaken and various arguments springing from ethical and legal disciplines are also incorporated from which pertinent principles, requirements and recommendations are suggested. There are a number of submissions, but the main submission is that the doctor must look for alternatives before resorting to therapeutic privilege. If all fail, then he/she can resort to the use of therapeutic privilege as a last resort. However the reason for non-disclosure must fall within the precise best interest standards stipulated and the physician must satisfy certain requirements to justify the invocation of the defence in order to escape liability. The defence of therapeutic privilege will only be legally justified when the above principles and requirements are met.

**Key terms:** Informed consent, therapeutic privilege, duty to inform, right to know, self-determination, autonomy, beneficence, non-maleficence



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# **CHAPTER 1**

## **INTRODUCTION**

### **1.1 BRIEF OVERVIEW OF INFORMED CONSENT AND THERAPEUTIC PRIVILEGE**

A growing acknowledgment of the importance of truth telling as an ethical principle brought with it the tension between truthfulness and the principles of beneficence and non-maleficence<sup>1</sup>. This tension acquired legal significance with the recognition of the doctor's duty to inform and the doctrine of informed consent<sup>2</sup>. In South Africa and other countries medical interventions are based on a patient's valid informed consent<sup>3</sup>. The most widely quoted judgment in medical consent is that of Benjamin Cardozo J which stands as a classic statement of the patient's right to self-determination:

'Every human being of adult years and sound mind has the right to determine what shall be done with his own body; and a surgeon who performs an operation without the patient's consent commits an assault, for which he is liable'<sup>4</sup>.

There are many exceptions to informed consent, but therapeutic privilege is one of them that has received the most attention<sup>5</sup>. Realizing that situations might arise in which disclosure of information may cause more harm to the patient, a need was identified to recognise an exception to the doctor's duty to disclose, hence the birth of the concept of therapeutic privilege. Therapeutic privilege can be defined as:

'The doctor's discretion to withhold information from the patient with regard to the diagnosis or nature of the proposed treatment and the risks involved, when the physician

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<sup>1</sup> Lodewicus Charles Coetzee *Medical Therapeutic Privilege* (unpublished LLM thesis, University of South Africa, 2001) 172.

<sup>2</sup> Ibid

<sup>3</sup> *Stoffberg v Elliot* 1923 CPD 148.

<sup>4</sup> *Schloendorff v Society of New York Hospital* 211 NY 125, 129-130; 105 NE 92 (1914).

<sup>5</sup> JG Malcom *Treatment Choices and Informed Consent Current Controversies in Psychiatric Malpractice Litigation* (1988) 89-91.

is of the opinion that the patient's state of mind is such that full awareness of the gravity and severity of his condition, or drastic nature of the treatment indicated, could be detrimental to such a degree that his recovery would be prejudiced<sup>6</sup>.

## **1.2 PURPOSE OF THE STUDY**

The National Health Act only recognizes therapeutic privilege when it is 'contrary to the user's best interest'<sup>7</sup> without stating exactly when it is in the patient's best interest. Similarly in the South African medical law landmark case of *Castell v De Greef*<sup>8</sup>, the court recognised the medical practitioner's therapeutic privilege. Ackermann J ruled that the obligation to warn a patient of a material risk inherent in a proposed treatment 'is subject to the therapeutic privilege, whatever the ambit of the so-called privilege may today still be'<sup>9</sup>.

Since legislation and common law do not allude to the ambit and parameters of the privilege, its precise nature and role in non-disclosure actions remain uncertain<sup>10</sup>. Therefore the purpose of this study is to explore the 'so-called therapeutic privilege', to give a critical evaluation of the defence and to flesh out its ambits.

## **1.3 STUCTURE OF THE STUDY**

The dissertation will be set out as follows:

Chapter 1- I have introduced and defined the concept of informed consent and therapeutic privilege and further stated that therapeutic privilege is indeed recognized as an exception to informed consent. Despite the recognition of therapeutic privilege as an exception as seen in NHA<sup>11</sup> and *Castell v De Greef*<sup>12</sup>, the boundaries of such a defence is uncertain.

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<sup>6</sup> P van den Heever 'Pleading the Defence of Therapeutic Privilege' (2005) 95 *SAMJ* 420, 420.

<sup>7</sup> S 6(1) and s 8(3) of the National Health Act 61 of 2003

<sup>8</sup> *Castell v De Greef* 1994 (4) SA 408 (C).

<sup>9</sup> *Castell v De Greef* 1994 (4) SA 408 (C) at 426H.

<sup>10</sup> P van den Heever 'The Patients Right to Know: Informed Consent in South African Medical Law' 1995 *De Rebus* 53, 56.

<sup>11</sup> S 6(1) and s 8(3) of the National Health Act 61 of 2003.

<sup>12</sup> *Castell v De Greef* 1994(4) SA 408 (C) at 426H.

The first chapter is a brief introduction into the dissertation as it sets out the purpose for having chosen this topic and such purpose is with intention of defining the contours of the defence in an attempt to make the precise nature, role, scope and the practical application of therapeutic privilege in the South African legal system more clear and certain as to when the defence is legally justified.

Chapter 2- The doctrine of informed consent, its parameters and the exceptions will be introduced. The provision of the Constitution<sup>13</sup> will restrict the parameters of informed consent where such limitation is reasonable and justifiable. Defining the parameters of the patient's informed consent in terms of the Constitution, legislation, common law and ethics before defining the parameters of therapeutic privilege is important, because it logically flows that the wider the parameters of informed consent, the narrower the scope of therapeutic privilege becomes. Thereafter I will also briefly mention the other existing exceptions to informed consent as it stands in our law, leaving the main exception of therapeutic privilege as a focus for the next few chapters.

Chapter 3- I will discuss how therapeutic privilege is recognized in South African law in terms of Constitution, legislation, common law, ethics and academic writers. By doing so I will also illustrate that despite its recognition, there are several gaps that need to be addressed. Firstly, I will emphasize that there are no precise circumstances in which it will be in the patient's best interest to invoke the defence and secondly, there are no set requirements that have to be met by the physician in order to justify his/her defence and escape liability, which makes the contours of the defence unclear.

Chapter 4- In this chapter I will use common law countries as a basis and expound the South African law against an international law background. This will be achieved by providing a short summary of a few cases— and legislation held in the United Kingdom, United States of America, Australia and Canada in which therapeutic privilege has enjoyed pertinent discussion and what the courts have held regarding the defence. The diverse formulations of therapeutic privilege found in the literature and case law are

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<sup>13</sup> S 36 of the Constitution of the Republic of South Africa, 1996.



classified according to the harm that it sought to avoid. In essence it will be evident that these comparative precedents should set out the best interest standard as well as the requirements that have to be met by the physician to justify his defence and escape liability.

Chapter 5- This chapter will be devoted to a critique of the defence whereby legal and ethical arguments will be considered for and against the defence. For each argument opposing the defence, I will present arguments in favor of the defence with the intention to balance the arguments. Furthermore I intend using these arguments in favor of the defence as an additional requirement that the physician has to meet in order to justify his defence and escape liability.

Chapter 6- It is important to mention the role of improving communication skills as it plays an important part in addressing the doctor's dilemma. I will reiterate some of the principles and requirements I have made at the end of each chapter as well as introduce some recommendations, so that the objective of this study is achieved. This will ensure that the reader has a clear understanding of the objective from the start and in the end will see that if the best interest standards are met and the physician has satisfied his/her requirements, the defence of therapeutic privilege should be legally justified and the physician can escape liability for non-disclosure. Only then will the role and parameters of therapeutic privilege become clear in future and not remain uncertain as it stands now.

## **CHAPTER 2**

### **INFORMED CONSENT AND ITS EXCEPTIONS IN SOUTH AFRICA**

#### **2.1 INTRODUCTION**

It is of extreme importance to define the parameters of the patient's right to informed consent before expanding on the exception of therapeutic privilege. Reason being, the wider the parameters of informed consent, the narrower the scope of therapeutic privilege becomes.

Traditionally the doctor -patient relationship was based on medical paternalism, which differed substantially from the doctor- patient relationship that exists today<sup>1</sup>. Previously the doctor was deemed to have had specialized knowledge and considered the best person to make a decision in the best interest of the patient without the patient's consent<sup>2</sup>. However this approach was only significant to the past whereby patients were presumed to be uneducated, or competent but unable to perceive what is best for his/her health thus rendering them incapable of fulfilling a balanced role in the doctor patient relationship<sup>3</sup>. Today medical paternalism and its premise of 'the doctor knows whats best' is entirely rejected in South African law and replaced by the doctrine of informed consent<sup>4</sup>.

#### **2.2 DOCTRINE OF INFORMED CONSENT**

The objective of the doctrine of informed consent is to aid rational decision making by allowing the patient to weigh up advantages and disadvantages disclosed to them in an attempt to reach a conclusion as to whether or not to undergo the proposed treatment<sup>5</sup>. Ultimately the decision whether or not to forgo the health service is entirely up to the patient and not the medical practitioner. The doctor's rights to treat or operate on a patient

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<sup>1</sup> D Giesen, 'From Paternalism to Self-Determination and Shared Decision Making' 1988 *Acta Juridica* 107, 114.

<sup>2</sup> Ibid

<sup>3</sup> M Beard & JR Midgley 'Therapeutic Privilege and Informed Consent: A Justified Erosion of Patient Autonomy' (2005) 51 *THRHR* 51, 56.

<sup>4</sup> Giesen (note 1 above) 116.

<sup>5</sup> Beard & Midgley (note 3 above) 56.

is based entirely on the patient's consent<sup>6</sup>. The principle of consent can be summarized as follows:

'A physician must not treat or even touch a patient without the patient's valid consent. Any competent person may refuse to accept medical attention, however foolish he maybe in doing so, even if he dies as a result. No physician may impose medical care on a person against his/her will, no matter how beneficial or necessary it may be<sup>7</sup>.

If a patient consents to risks of harm, his/her consent operates as a defence negating wrongfulness, making the ensuing harm lawful<sup>8</sup>. There are different requirements for consent established and recognized in South Africa. I intend to first discuss the elements of consent before moving onto the requirements in terms of the Constitution, statute, common law, policy and ethics.

## **2.3 ELEMENTS OF INFORMED CONSENT**

### **2.3.1 Disclosure**

Section 6(1) of the NHA<sup>9</sup> provides that every health care provider must inform the patient of the different diagnosis procedures, options available, benefits, risks, cost and consequences. Generally the law places emphasis on the disclosure of risks. *Castell v De Greef*<sup>10</sup> states that it is the material risks that need to be disclosed. The court attempted to provide guidance for physicians by suggesting that the duty to disclose risks increases as the risks increases hence full disclosure is not a requirement. The court stated that all severe, less severe and even possible risks should be disclosed to the patient. Nominal risks with low probability of occurrence need not be disclosed<sup>11</sup>. Ethically, according to

<sup>6</sup> M Beard & JR Midgley 'Therapeutic Privilege and Informed Consent: A Justified Erosion of Patient Autonomy' (2005) 51 *THRHR* 51, 52.

<sup>7</sup> Patrick van der Heever *Therapeutic privilege in South African Medical Law* (unpublished LLM thesis, University of Cape Town, 1997) 4.

<sup>8</sup> *Castell v De Greef* 1994 (4) SA 408 (C) 420H, 423B-D ; Lodewicus Charles Coetzee *Medical Therapeutic Privilege* (unpublished LLM thesis, University of South Africa, 2001) 2-3.

<sup>9</sup> Section 6(1) of the National Health Act 61 of 2003

<sup>10</sup> *Castell v De Greef* 1994 (4) SA 408 (C) at 426

<sup>11</sup> Ibid

section 2.1 of the HPCSA<sup>12</sup> doctors are said to discuss the benefits and risks to allow the patient to make an informed decision thus respecting their autonomy. Section 3.1.1 of the HPCSA<sup>13</sup> further states that the information varies from patient to patient according to the nature of the condition, complexity of treatment risk and the patient's wishes. The most preferred standard of disclosure is referred to as the subjective standard. This standard indicates that for the principles of autonomy to be maximized, the level of disclosure of relevant information should be tailed to the patient based on his/her informational needs<sup>14</sup>. This will be further dealt with in the National Health Act<sup>15</sup> and *Castell v De Greef*<sup>16</sup>.

### 2.3.2 **Understanding**

According to the s6(2) of the NHA<sup>17</sup> the health care provider must provide information to the patient in a language the user understands, taking into account their level of literacy. Understanding was also evidenced in the case of *Castell v De Greef*<sup>18</sup> in which it was stated that the patient must be able to appreciate and understand the disclosure of the risks. Section 4.2.1 of the HPCSA<sup>19</sup> reflects the common law position of understanding.

Physicians encourage patients to ask questions and clarify ambiguous information. If understanding the English language creates difficulty, an interpreter must be provided. If the patient has difficulty hearing or seeing, assistive devices need to be made available to ensure communication between the physician and patient is optimized<sup>20</sup>. This will be further dealt with in the National Health Act<sup>21</sup> and *Castell v De Greef*<sup>22</sup>.

<sup>12</sup> HPCSA, *Seeking Patients Informed Consent: The Ethical Considerations*: Booklet 9 (2008), para 2.1

<sup>13</sup> *Ibid*, para 3.1.1

<sup>14</sup> H Osman 'History and Development of the Doctrine of Informed Consent' (2001) 4 *The International Electronic Journal of Health Education* 41, 44.

<sup>15</sup> See para 2.5.1 below.

<sup>16</sup> See para 2.6 below.

<sup>17</sup> Section 6(2) of the National Health Act 61 of 2003

<sup>18</sup> *Castell v De Greef* 1994 (4) SA 408 (C) at 426

<sup>19</sup> HPCSA, *Seeking Patients Informed Consent: The Ethical Considerations*: Booklet 9 (2008), para 4.2.1

<sup>20</sup> H Osman 'History and Development of the Doctrine of Informed Consent' (2001) 4 *The International Electronic Journal of Health Education* 41, 44.

<sup>21</sup> See para 2.5.1 below.

<sup>22</sup> See para 2.6 below.

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### 2.3.3 **Patient must consent freely and voluntarily**

Consent must be given without fear, coercion, duress or undue influence by family or the physician<sup>23</sup>. If consent is the result of physical force or psychological pressure especially over vulnerable persons, then consent is vitiated. ~~Financial rewards offered in exchange for consent also invalidates consent, because it induces a person to consent which they would not do so willingly~~<sup>24</sup>. ~~The patient must not be cognitively impaired by medication when giving consent. In the case of *Demers v Gerety*<sup>25</sup>, a patient was given a sedative to sleep and awakened in the middle of the night to give consent to an hernia operation. The court held that such consent was invalid, because the patient was unlikely to understand what permission he granted. According to the section 7.1 of the HPCSA<sup>26</sup> the health care providers are to ensure that the patient's decision is voluntary. The practitioners are only to advise the patient and not put pressure on them to accept such advice<sup>27</sup>. Financial rewards offered in exchange for consent also invalidates consent, because it induces a person to consent which they would not do so willingly~~<sup>28</sup>.

### 2.3.4 **Competence**

The Minnesota Office of Revisor of Statutes<sup>29</sup> states that capacity is the ability to understand the benefit and risk and to be able to communicate a meaningful decision. An element of capacity is that the person making the decision is an adult, not judged as incompetent or prohibited by law from making such decision.<sup>30</sup> ~~Only a consenting party that is capable of performing a juristic act has the capacity to consent.~~ In other words a

<sup>23</sup> *R v McCoy* 1953 2 SA 4 (SR); M Beard & JR Midgley 'Therapeutic Privilege and Informed Consent: A Justified Erosion of Patient Autonomy' (2005) 51 *THRHR* 51, 53.

Erosion of Patient Autonomy' (2005) 51 *THRHR* 51, 53.

<sup>24</sup> J Burchell 'Informed Consent-Variation on a Familiar Theme' (1986) 5 *Medicine and the Law* 320, 320; Patrick van den Heever *Therapeutic Privilege in South African Medical Law* (unpublished LLM thesis, University of Cape Town, 1997) 8.

<sup>25</sup> *Demers v Gerety* 85 NM 641 515 P 2d 645 (1972).

<sup>26</sup> HPCSA, *Seeking Patients Informed Consent: The Ethical Considerations*: Booklet 9 (2008), para 7.1

<sup>27</sup> *Ibid*

<sup>28</sup> J Burchell 'Informed Consent-Variation on a Familiar Theme' (1986) 5 *Medicine and the Law* 320, 320; Patrick van den Heever *Therapeutic Privilege in South African Medical Law* (unpublished LLM thesis, University of Cape Town, 1997) 8.

<sup>29</sup> Minnesota Office of Revisor of Statutes 'Decision-making Capacity' Minn Stat 145C 01 Subd 1b

<sup>30</sup> *Ibid*

person must be in his/her sound or sober senses to give valid consent<sup>31</sup>. The person must be intellectually mature enough to appreciate the implications of his/her conduct. Example in the case of minors, there are instances where the minor will be able to consent autonomously and cases where they can not. This will be discussed below regarding requirements of competence as stipulated in legislation<sup>32</sup> below. Castell v De Greef<sup>33</sup> also states that a patient must have the capacity to consent. Section 9.2.2 of the HPCSA<sup>34</sup> states that the health care practitioner should record the decision while the patient was competent and further s9.2.3<sup>35</sup> says that the practitioner should constantly review such decision at intervals before treatment starts in order to establish whether the views are consistently held and can be relied on.

#### 2.3.5 **Consent**

According to s7(2) of the NHA<sup>36</sup> the health care provider must take all reasonable steps to obtain informed consent. This is in accordance with *Stoffberg v Elliot*<sup>37</sup> whereby it was held that the medical intervention is based on a patient's valid informed consent. In the case of *Castell v De Greef*<sup>38</sup> it was held that cConsentonsent must be clear, comprehensive, extend to the entire transaction –and unequivocal which precedes the medical intervention<sup>39</sup>. Section 4.1.4 of the HPCSA<sup>40</sup> also places emphasis on consent and its comprehensiveness. This will be death with in legislation<sup>41</sup> and common law<sup>42</sup> set out below, but mainly in the National Health Act 61 of 2003 and *Castell v De Greef*

—Town, 1997) 8.

<sup>31</sup> M Beard & JR Midgley 'Therapeutic Privilege and Informed Consent: A Justified Erosion of Patient Autonomy' (2005) 51 *THRHR* 51. 54 ~~Beard & Midgley (note 15 above) 54.~~

<sup>32</sup> See para 2.5 below.

<sup>33</sup> *Castell v De Greef* 1994 (4) SA 408 (C) at 426

<sup>34</sup> HPCSA, *Seeking Patients Informed Consent: The Ethical Considerations*: Booklet 9 (2008), para 9.2.2

<sup>35</sup> HPCSA, *Seeking Patients Informed Consent: The Ethical Considerations*: Booklet 9 (2008), para 9.2.3

<sup>36</sup> Section 7(2) of the National Health Act 61 of 2003

<sup>37</sup> *Stoffberg v Elliot* 1923 CPD 148

<sup>38</sup> *Castell v De Greef* 1994 (4) SA 408 (C) at 426

<sup>39</sup> Van den Heever (note 16 above) 24.

<sup>40</sup> HPCSA, *Seeking Patients Informed Consent: Th Ethical Considerations*: Booklet 9 (2008), para 4.1.4

<sup>41</sup> See para 2.5 below.

<sup>42</sup> See para 2.6 below.

1994 (4) SA 408 (C).

### 2.3.6 **The consent must not be contrary to public policy**

Consent must be allowed by law. In other words consent must be in accordance with *boni mores* and legal convictions of the community. If the consent is objectively unreasonable to norms of society, then we refer to it as *contra boni mores* and it will be regarded as invalid. Consent to a torture or reckless experiment will be *contra boni mores*, because of the protection afforded to life and bodily integrity in the Constitution<sup>43</sup>.

In the *Gillick v West Norfolk and Wisbeck Area Health Authority*<sup>44</sup> case, Mrs Gillick was a Roman Catholic of 5 daughters. She brought a declaration that a doctor would be acting unlawfully if he gave contraceptive treatment to her daughters without her consent. It was argued that teenage pregnancies would increase if the courts ruled that parental consent was necessary. On the other hand it was argued that the judges would be encouraging sex if they did not. It was held by the majority that a child under the age of 16 who can fully understand the implications of the proposed treatment can give her own consent to medical treatment as it would be in the best interest of the child as well as in the best interest of the public. Similarly the Choice on Termination of Pregnancy Act<sup>45</sup> allows a female of any age to terminate her pregnancy if she can autonomously consent to such procedure. This is also in accordance with *boni mores* of society. Furthermore the National Health Act<sup>46</sup> is public law and therefore it is in the best interest of the public when it takes into account valid informed consent.

### 2.3.7 **Consent must be given by the patient personally**

It is preferable for the consent to be given by the patient him/herself in all circumstances, except where the patient is unconscious, mentally incapable or a minor<sup>47</sup>. Section 7(a)(i)

<sup>43</sup> M Beard & JR Midgley 'Therapeutic Privilege and Informed Consent: A Justified Erosion of Patient Autonomy' (2005) 51 *THRHR* 51, 55.

<sup>44</sup> *Gillick v West Norfolk and Wisbeck Area Health Authority* (1985) 3 ALL ER 402 HL

<sup>45</sup> Section 5(1) and 5(2) of the Choice on Termination of Pregnancy Act 92 of 1996

<sup>46</sup> National Health Act 61 of 2003

<sup>47</sup> SA Strauss *Doctor, Patient and the Law: A Selection of Practical Issues* 3ed (1991) 3 ; Patrick van den Heever *Therapeutic Privilege in South African Medical Law* (unpublished LLM thesis, University of Cape Town, 1997) 22.

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of the NHA<sup>48</sup> provides for substituted consent if the patient is unable to consent. Such person will consent on behalf of the patient if mandated to do so in writing by the patient when he/she was competent. Section 7(a)(ii) of the NHA<sup>49</sup> further states that a person can also consent in terms of law or a court order. In the absence of the above, a spouse/partner, parent, grandparent, major child, or sibling can consent. Section 9.3.3 of the HPCSA<sup>50</sup> states that the health care practitioner must refer to the Mental Health Care Act 17 of 2002 when dealing with mentally ill patient and refer to the Children's Act 38 of 2005 when assessing whether a child has the capacity to consent.

#### 2.3.8 **Consent may be express or implied**

Consent can be given by a patient expressly by verbal or written agreement or tacitly by conduct<sup>51</sup>. Section 13 of the HPCSA<sup>52</sup> provides that the nature of the risk makes it important that a written record is available. The law does not stipulate that written consent should be a pre-requisite, however in the case of operation the patient's written consent is usually a requirement. It is necessary in complex matters where theres consequences for the patient's employment, social life or treatment necessary for a research programme<sup>53</sup>. It also ensures understanding between the health care practitioner, patient and everyone carrying out the procedure<sup>54</sup>. It is submitted that consent in writing is also advisable, because it serves as *prima facie* proof of consent in any malpractice litigation that should arise in future<sup>55</sup>. Section 15 of the HPCSA<sup>56</sup> also states that the practitioner should be careful about compliance as a form of consent. Submission may not indicate consent. Fact that a patient lies down does not mean that they are consenting<sup>57</sup>. It is preferable for consent to be expressed rather than implied to avoid

<sup>48</sup> Section 7(a)(i) of the National Health Act 61 of 2003

<sup>49</sup> Section 7(a)(ii) of the National Health Act 61 of 2003

<sup>50</sup> HPCSA, *Seeking Patients Informed Consent: The Ethical Considerations*: Booklet 9 (2008), para 9.3.3

<sup>51</sup> Patrick van den Heever *Therapeutic Privilege in South African Medical Law* (unpublished LLM thesis, University of Cape Town, 1997) 22. ~~Van den Heever (note 23 above) 22.~~

<sup>52</sup> HPCSA, *Seeking Patients Informed Consent: The Ethical Considerations*: Booklet 9 (2008), para 13

<sup>53</sup> *Ibid*

<sup>54</sup> HPCSA, *Seeking Patients Informed Consent: The Ethical Considerations*: Booklet 9 (2008), para 13

<sup>55</sup> SA Strauss *Doctor, Patient and the Law: A Selection of Practical Issues* 3ed (1991) 12 ; Patrick van den Heever *Therapeutic Privilege in South African Medical Law* (unpublished LLM thesis, University of Cape Town, 1997) 22-23. ~~Strauss (note 23 above) 12 ; Van den Heever (note 23 above) 22-23.~~

<sup>56</sup> HPCSA, *Seeking Patients Informed Consent: The Ethical Considerations*: Booklet 9 (2008), para 15

<sup>57</sup> *Ibid*



confusion.

Apart from the elements mentioned above, informed consent is recognised as the legal rule of self-determination underlined by the ethical principle of autonomy. In other words the foundational principle is based on the premise of respect for self-determination and autonomy, which lies at the heart of the doctor-patient relationship<sup>58</sup>. It is crucial to discuss the law first before expanding on ethics as an underlying principle.

## 2.4 CONSTITUTION

### 2.4.1 Informed Consent and the Constitution of the Republic of South Africa, 1996

From a legal perspective, section 12(2)(b)<sup>59</sup> states that everyone has the right to bodily and psychological integrity, which includes the right to security and control over one's own body. It then becomes clear that self-determination has been afforded constitutional protection in this section itself, allowing all patients in South Africa to have the right of free choice and informed consent in the healthcare context. Section 12(2)(c)<sup>60</sup> prohibits research without the participants informed consent. Withholding information from the participant regarding experimentation means they are unable to meet the legal obligation to protect themselves<sup>61</sup>. Therefore the participants are entitled to risk/benefit information so that they can evaluate long term consequences, weigh the risks and benefits, consider the short term effects and future interests of others before making an informed decision

<sup>58</sup> D Welz 'The Boundaries of Medical Therapeutic Privilege' (1999) 116 *SALJ* 299, 301.

<sup>59</sup> S 12(2)(b) of the Constitution of the Republic of South Africa, 1996.

<sup>60</sup> S 12(2)(c) of the Constitution of the Republic of South Africa, 1996.

<sup>61</sup> C. Slack et al 'Enrolling Adolescents in HIV Vaccine trials: Reflections on Legal Complexities from SA (2007) 8 *BMC Medical Ethics* 5.

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whether to participate in the medical/scientific experimentation<sup>62</sup>.

The NHA supplements the Constitution with regard to consent to scientific/medical experimentations regarding children. A brief discussion of children's consent to research is essential to encapsulate the importance of ascertaining consent before proceeding with any medical/scientific experiment. In terms of the NHA extra consent is required in regarding minors since they are identified as a vulnerable group. The act distinguishes between therapeutic and non-therapeutic research. Therapeutic research on a child may occur with the consent of the minor if he/she is capable of understanding, his/her guardian/parent and if such research is in the best interests of the child<sup>63</sup>. Non therapeutic research maybe performed on a minor under the same conditions, but it need not be in the best interests of the child. The additional consent of the Minister is required<sup>64</sup>. The Minister may not authorize consent where the reasons for consent by the minor or parent/guardian are contrary to public policy, if the research can be conducted on an adults and the risks outweigh the benefit or if there is significant risk to the health of the minor<sup>65</sup>.

Section 9<sup>66</sup> states that everyone must be treated equally. Section 9(2)<sup>67</sup> provides that equality includes full enjoyment of all rights and freedoms which indicates that there should be a prohibition of discrimination on any grounds mentioned in s9(3)<sup>68</sup> as a reason for denying a patient access to information and giving informed consent. However there are exceptions with regard to age and disability. These will be discussed below in terms of requirements of legislation<sup>69</sup> as well as the exception of incompetence<sup>70</sup>. A person's inherent dignity is respected and protected if they are given adequate information

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<sup>62</sup> Ibid

<sup>63</sup> S 71(2) of the National Health Act 61 of 2003.

<sup>64</sup> S 71(3)(a) of the National Health Act 61 of 2003.

<sup>65</sup> S 71(3)(b) of the National Health Act 61 of 2003.

<sup>66</sup> S 9 of the Constitution of the Republic of South Africa, 1996.

<sup>67</sup> S 9(2) of the Constitution of the Republic of South Africa, 1996.

<sup>68</sup> S 9(3) grounds of discrimination include: race, gender, sex, pregnancy, marital status, ethnic or social origin, color, sexual orientation, age, disability, religion, conscience, belief, culture, language, and birth.

<sup>69</sup> See para 2.5 below.

<sup>70</sup> See para 2.9.3 below.

in order to make an informed decision<sup>71</sup>. The right to privacy<sup>72</sup> include the right to be given any information held by the medical practitioner and the right to know what is written in his/her medical file about their condition.

It is trite law that every person has the right to determine what will happen to his/her own body, which includes a right to decide whether to submit themselves to a medical intervention. Therefore the patient has a right to be fully informed and the doctor has the duty to disclose such information to enable the patient to make an informed decision<sup>73</sup>.

## **2.5 LEGISLATION**

### **2.5.1 Informed Consent and the National Health Act (NHA)**

The act makes specific reference to informed consent and is designed to give effect to the Constitution in terms of access to health. Section 6(1)<sup>74</sup> provides that every health care provider must inform the user of: (b) the range of diagnosis procedures and treatment options available (c) benefits, risks, cost and consequences associated with each option and (d) the user's right to refuse treatment explaining the implications, risks, obligations of such refusal. The health care provider is required to inform the user in a language the user understands and in manner that take into account the user's level of literacy<sup>75</sup>. Complex medical jargon should be avoided and the the medical practitioner must make every attempt to ensure that the patient actually comprehends what he/she is being told<sup>76</sup>. According to s7(2)<sup>77</sup>, a health care provider must take all the reasonable steps to obtain the users informed consent.

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<sup>71</sup> S 10 of the Constitution of the Republic of South Africa 1996.

<sup>72</sup> S 14 of the Constitution of the Republic of South Africa 1996.

<sup>73</sup> P van den Heever 'Patient's Right to Know: Informed Consent in South African Medical Law' 1995 *De Rebus* 53, 53.

<sup>74</sup> S 6(1) of the National Health Act 61 Of 2003.

<sup>75</sup> S 6(2) of the National Health Act 61 Of 2003.

<sup>76</sup> M Beard & JR Midgley 'Therapeutic Privilege and Informed Consent: A Justified Erosion of Patient Autonomy' (2005) 51 *THRHR* 51, 57.

<sup>77</sup> S 7(2) of the National Health Act 61 of 2003.

When it comes to emergency medical treatment the situation may be different in that emergency medical treatment is provided where the patient is incapable of giving consent<sup>78</sup>. The Constitution<sup>79</sup> and the NHA<sup>80</sup> both make provision for no person to be refused emergency medical treatment. Emergency medical treatment is one of the exceptions to informed consent which will be discussed below<sup>81</sup>.

#### 2.5.1.1 Mentally incompetent patients

These include ordinary competent adults who are found to be temporarily lacking capacity such as an unconscious, intoxicated individuals. In situations of incapacity section 7 of the NHA makes provision for 'substituted consent'. A person may consent on behalf of the patient if they have been mandated to do so in writing by the patient<sup>82</sup>. The patient must have been legally capable of delegating such authority at the time of doing so. A person may also consent on behalf of a patient in terms of any law or court order<sup>83</sup>. If the user is unable to give consent and in the absence of delegation, then the consent must be given by a spouse/partner, parent, grandparent, major child, brother or sister<sup>84</sup>. If consent is to be given by someone other than the patient as contemplated in s7(1)(a) and s7(1)(b) of the NHA, the patient must first be consulted<sup>85</sup>.

Section 8(1)<sup>86</sup> also provides that a user has the right to participate in any decision affecting his/her health or treatment. A user who is capable of understanding must be informed in terms of the act even if/she lacks legal capacity to give consent<sup>87</sup>.

#### 2.5.1.2 Treatment without consent

There exist circumstances in which the medical practitioner may proceed with the medical intervention without the patient's informed consent. Such circumstances include

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<sup>78</sup> S 7(1) of the National Health Act 61 of 2003.

<sup>79</sup> S 27(3) of the Constitution of the Republic of South Africa, 1996.

<sup>80</sup> S 5 of the National Health Act 61 of 2003.

<sup>81</sup> See para 2.9.2 below.

<sup>82</sup> S 7(a)(i) of the National Health Act 61 of 2003.

<sup>83</sup> S 7(a)(ii) of the National Health Act 61 of 2003.

<sup>84</sup> S 7(1)(b) of the National Health Act 61 of 2003.

<sup>85</sup> S 8(2)(a) of the National Health Act 61 of 2003.

<sup>86</sup> S 8(1) of the National Health Act 61 of 2003.

<sup>87</sup> S 8(2)(b) of the National Health Act 61 of 2003.

authorization in terms of any law or court order<sup>88</sup>, if failing to treat a user will result in a serious risk to the public health<sup>89</sup>, or if any delay in provision of health services may result in the patient's death or irreversible damage to his/her health<sup>90</sup>. These will also be further discussed under the exceptions to informed consent below<sup>91</sup>.

#### 2.5.1.3 Consent by children to research

~~In terms of the NHA extra consent is required in regarding minors since they are identified as a vulnerable group. The act distinguishes between therapeutic and non-therapeutic research. Therapeutic research on a child may occur with the consent of the minor if he/she is capable of understanding, his/her guardian/parent and if such research is in the best interests of the child<sup>92</sup>. Non-therapeutic research may be performed on a minor under the same conditions, but it need not be in the best interests of the child. The additional consent of the Minister is required<sup>93</sup>. The Minister may not authorize consent where the reasons for consent by the minor or parent/guardian are contrary to public policy, if the research can be conducted on an adults and the risks outweigh the benefit or if there is significant risk to the health of the minor<sup>94</sup>.~~

#### **2.5.2 Informed Consent and the Children's Act**

This act is another form of statutory authority for informed consent specifically with regard to children. In terms of s1 of the act, a child is defined as any person under the age of 18 years. Section 129 as discussed below also covers situation in which the child is mentally ill to the extent that they are not capable of consenting to treatment<sup>95</sup>.

##### 2.5.2.1 Consent to treatment and surgical operations by children

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<sup>88</sup> S 7(1)(c) of the National Health Act 61 of 2003.

<sup>89</sup> S 7(1)(d) of the National Health Act 61 of 2003.

<sup>90</sup> S 7(1) (e) of the National Health Act 61 of 2003.

<sup>91</sup> See para 2.9.2 below.

<sup>92</sup> S 71(2) of the National Health Act 61 of 2003.

<sup>93</sup> S 71(3)(a) of the National Health Act 61 of 2003.

<sup>94</sup> S 71(3)(b) of the National Health Act 61 of 2003.

<sup>95</sup> LC Coetzee & L Pienaar *Medical Law Study Guide* (2012) 89-90 ; Patrick van den Heever *Therapeutic Privilege in South African Medical Law* (unpublished LLM thesis, University of Cape Town, 1997) 112.

The act states that a child may consent to his/her own medical treatment<sup>96</sup> or surgical operation<sup>97</sup> on his/herself or his/her child if the (a) child is over the age of 12 years and (b) of sufficient maturity and has the mental capacity to understand the benefits, risks and social implications. In the case of surgical operations there is an additional requirement, which is that the child needs to be duly assisted by his/her parent or guardian.

If the child is under the age of 12 or over 12 but of insufficient maturity and unable to understand the benefits, risks or implications of treatment<sup>98</sup> or surgery<sup>99</sup>, then the parent or guardian must consent on their behalf.

The superintendent of the hospital or the person in charge in the absence of the superintendent may consent to the medical treatment or surgical operations on the child if (a) the treatment or operation is necessary to preserve the life of the child or save the child from serious or lasting physical injury or disability (b) the need for treatment or operation is so urgent that it cannot be deferred for the purposes of obtaining consent<sup>100</sup>.

The Minister of Social Development can consent to medical treatment or surgical operations on a child if the parent or guardian (a) unreasonably refuses to give consent or assist the child (b) incapable of giving consent or assisting the child (c) cannot readily be traced or (d) is deceased<sup>101</sup>. The Minister's consent must be based on the best interest of the child<sup>102</sup>.

If the child unreasonably refuses medical treatment or surgical operations, the Minister of Social Development can consent on behalf of the child<sup>103</sup>. Such intervention by the Minister maybe said to be unconstitutional as it offends the right to freedom and security of a person. However, the counter argument could easily be that s129(8) is an extension

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<sup>96</sup> S 129(2) of the Children's Act 38 of 2005.

<sup>97</sup> S 129(3) of the Children's Act 38 of 2005.

<sup>98</sup> S 129(4) of the Children's Act 38 of 2005.

<sup>99</sup> S 129(5) of the Children's Act 38 of 2005.

<sup>100</sup> S 129(6) of the Children's Act 38 of 2005.

<sup>101</sup> S 129(7) of the Children's Act 38 of 2005.

<sup>102</sup> DJ McQuoid-Mason 'Can Children Aged 12 Years Refuse Life Saving Treatment Without Consent or Assistance from Anyone Else?' (2014) 104 *SAMJ* 466, 467.

<sup>103</sup> S 129(8) of the Children's Act 38 of 2005

of the principle of best interests of the child<sup>104</sup>.

The High Court or Children's Court can be approached to give consent to treatment or surgery in instances where another person refuses or is unable to give consent<sup>105</sup>. The common law position states that the High Court acts as a upper guardian of all minors and has the inherent power to protect children and promote their best interest in all matter concerning them<sup>106</sup>.

No parent or guardian may refuse to assist a child or withhold consent by reason of religious or other beliefs, unless they can show that there is a medically accepted alternative choice to the medical treatment or operation<sup>107</sup>.

#### 2.5.2.2 Consent in terms of HIV testing on children

The act provides that a child may consent to an HIV test if such test is in the child's best interest<sup>108</sup> and the child is 12 years or older. A child under the age of 12 may consent provided he/she is of sufficient maturity to understand the benefits, risks and social implications of the HIV tests<sup>109</sup>. Section 130(1)(b)<sup>110</sup> provides that if it is not in the best interest of the child, an HIV test may only be carried out with the consent of the court if it is necessary to establish if a health worker or any person maybe at risk HIV contraction due to contact with bodily fluid from the child.

Section 130(2)<sup>111</sup> of the act deals with children who are under the age of 12 and do not have sufficient maturity to understand the benefits, risks and social implications of an HIV test. Therefore the act stipulates persons who may consent on behalf of the child. These include the parents or guardian, provincial head of social development, the

<sup>104</sup> J Malherbe & A Govindjee 'A Question of Blood: Constitutional Perspective on Decision Making about Medical Treatment of Children of Jehovah's Witness (2010) 73 *THRHR* 61, 72.

<sup>105</sup> S 129(9) of the Children's Act 38 of 2005.

<sup>106</sup> J Malherbe & A Govindjee 'A Question of Blood: Constitutional Perspective on Decision Making about Medical Treatment of Children of Jehovah Witness' (2010) 73 *THRHR* 61. (Note 66 above) 73.

<sup>107</sup> S 129(10) of the Children's Act 38 of 2005.

<sup>108</sup> S 130(1)(a) of the Children's Act 38 of 2005.

<sup>109</sup> S 130(2)(a)(i) & s 130(2)(a)(ii) of the Children Act 38 of 2005.

<sup>110</sup> S 130(1)(b) of the Children's Act 38 of 2005.

<sup>111</sup> S 130(2) of the Children's Act 38 of 2005.

designated child protection organization currently arranging placement for the child, the superintendent of the hospital in the absence of the above, or lastly the Children's Court if consent is reasonably withheld by anyone including the child.

Pre and post-test counseling should be provided by trained persons. Pre-test counseling includes the disclosure of benefits, risk and social implication whereas post counseling involves implications of the results. In both cases counseling must be afforded to the child of sufficient maturity and to the child's parent/guardian if they have knowledge of the test<sup>112</sup> or the child is of insufficient maturity. Informed consent also applies in the case of prisoners. Prisoners also have the right to give informed consent for an HIV test<sup>113</sup>. In the case of *C v Minister of Correctional Services*, the information about the test, its object and the right to refuse was communicated to the prisoners in a group and there was no privacy and little time to reflect<sup>114</sup>. Furthermore there was no pre counseling and post counseling as part of the informed consent process, which was wrongful and material<sup>115</sup>. Since the consent for the blood sample to be taken for an HIV test was regarded as invalid, the court held that prisoners had an action for invasion of the prisoners privacy against the Minister of Correctional Services<sup>116</sup>.

#### 2.5.2.3 Consent by children to contraception

Section 134(1)<sup>117</sup> provides that no person may refuse to sell condoms to a child over the age of 12 or provide it on request especially when the condoms are free of charge. This implies that children under the age of 12 maybe refused condoms. This section applies to both male and female condoms. Contraceptives apart from condoms maybe provided without consent if the child is 12 years or older, proper medical advice is given and a medical examination is carried out to determine if there are any reasons prohibiting the child such access<sup>118</sup>. In addition the act ensures that every child enjoys the right to confidentiality regarding his/her health status and information regarding

<sup>112</sup> S 132(1) and s 132(2) of the Children's Act 38 of 2005.

<sup>113</sup> *C v Minister of Correctional Services* 1996 (4) SA 292 (T) at 303-304.

<sup>114</sup> *C v Minister of Correctional Services* 1996 (4) SA 292 (T) at 304.

<sup>115</sup> *C v Minister of Correctional Services* 1996 (4) SA 292 (T) at 304.

<sup>116</sup> *C v Minister of Correctional Services* 1996 (4) SA 292 (T) at 304.

<sup>117</sup> S 134(1) of the Children's Act 38 of 2005.

<sup>118</sup> S 134(2) of the Children's Act 38 of 2005.



contraceptives<sup>119</sup>.

#### 2.5.2.4 Virginity Testing

The Children's Act provides that no person under the age of 16 may be subject to virginity testing. Once over the age of 16 virginity testing may be conducted with the consent of the individual after proper counseling of the child in the prescribed manner<sup>120</sup>.

#### 2.5.2.5 Circumcision

Female children may not be circumcised. Male children under the age of 16 may not be circumcised unless it is performed for religious purposes in accordance with practices of religion and in the prescribed manner, or where the medical practitioner is of the opinion that circumcision should be performed for medical reasons<sup>121</sup>. Male children over the age of 16 may be circumcised if the child has consented after the child has been properly counseled and in the manner prescribed<sup>122</sup>. Every male child has the right to refuse circumcision with due regard paid to the child's age, maturity and stage of development<sup>123</sup>. Parents may not override the decision not to be circumcised.

### 2.5.3 **Informed Consent and The Choice on Termination of Pregnancy Act (CTOP)**

The act allows for termination of pregnancy on any female of any age. This is not affected by the age requirements as set out in the Children's Act. The CTOP act envisages that a minor female must provide informed<sup>124</sup> consent autonomously to a termination of pregnancy without her parents or guardians consent<sup>125</sup>. This means that the female must be of sufficient maturity and mental capacity to understand, appreciate and voluntarily consent to the benefits, risks and social implications. However the medical practitioner or

<sup>119</sup> S 134(3) of the Children's Act 38 of 2005.

<sup>120</sup> S 12(5) of the Children's Act 38 of 2005.

<sup>121</sup> S 12(8) of the Children's Act 38 of 2005.

<sup>122</sup> S 12(9) of the Children's Act 38 of 2005.

<sup>123</sup> S 10 of the Children's Act 38 of 2005.

<sup>124</sup> S 5(1) of the Choice on Termination of Pregnancy Act 92 of 1996.

<sup>125</sup> S 5(2) of the Choice on Termination of Pregnancy Act 92 of 1996.

the registered midwife shall advise the minor to consult with her parent or guardian prior to the procedure. The minor should not be denied access to a termination procedure should she refuse to consult with family members as advised.

There has been a dispute regarding the age requirement in terms of woman giving informed consent for a termination of pregnancy. In the *Christian lawyers Association v Minister of Health and Others*<sup>126</sup>, the plaintiffs argued that the CTOP Act was unconstitutional because it allowed a female under the age of 18 to have an abortion without her parents consent as such female is insufficiently mature to decide on the matter<sup>127</sup>. The court disposed of the matter on the ground that the act requires informed consent from the woman having the termination and thus implies knowledge and appreciation of the knowledge. Young children who are not sufficiently mature or developed will not have such capacity for knowledge, appreciation and thus cannot consent. The common law requirement that such minors need the assistance of a parent or guardian to a termination would then apply<sup>128</sup>. Hence the the CTOP act is constitutional.

#### ~~2.5.4 Informed Consent and the Criminal Law (Sexual Offences and Related Matters) Amendment Act (Sexual Offences Act)~~

~~Age at which a child is considered by law to be mature enough and capable to consent to sexual intercourse is 16 years<sup>129</sup>. An adult or child having sex with a child under 12 will be guilty of rape or sexual violation and consent by the child will offer no valid defence<sup>130</sup>. It is an offence for an adult or child to have sex with a child between 12 and 16. Where both the accused and victim are between 12 and 16, they both can be charged with statutory rape. Further a victim or interested party on behalf of a victim of sexual offence can apply to the magistrate for compulsory HIV testing of the offender<sup>131</sup>. In such case the consent of the offender to such test is not required.~~

<sup>126</sup> *Christian Lawyers Association v Minister of Health and Others* 2005 (1) SA 509 (T).

<sup>127</sup> *Christian Lawyers Association v Minister of Health and Others* 2005 (1) SA 509 (T) at 513.

<sup>128</sup> *Christian Lawyers Association v Minister of Health and Others* 2005 (1) SA 509 (T) at 515-516.

<sup>129</sup> S 1(1)(b) of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007.

<sup>130</sup> S 57 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007.

<sup>131</sup> S 30(1)(a)(i) of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007.

#### **2.5.45 Informed Consent and the Sterilization Act**

Any person over the age of 18 capable of consenting maybe sterilized on request<sup>132</sup>. Section 2<sup>133</sup> of the act provides that no person under the age of 18 maybe sterilized, except where failure to do so would seriously jeopardizes the patients life or physical health. In cases of sterilization the doctors should ensure that the consent of the patient spouse has also been obtained.

#### **2.5.56 Informed Consent and the Mental Health Care Act**

It should be noted that not all mentally ill patients are incapable of consenting. Seriously mentally ill patient may experience lucid intervals where they are capable of giving legally valid informed consent. A mentally ill patient is unable to consent if the mental illness prevents the patient from understanding what he/she is consenting to from choosing decisively, from communicating his/her consent or if the mental illness prevents the patient from accepting that he/she need medical assistance. The act provides that healthcare may only be provided if the mentally ill patient has consented or if treatment is authorized by a court order or a review board<sup>134</sup>. Furthermore medical interventions maybe provided if any delay in treatment may result in their death or irreversible harm, the user inflicting serious harm to his/herself or other or causing serious damage or loss to property belonging to himself or anyone else<sup>135</sup>.

### **2.6 INFORMED CONSENT AND COMMON LAW**

The common law principles demonstrated in cases below illustrate that the courts are adopting a more patient-focused approach. The reason behind such rationale is the recognition of the fundamental right of self-determination and autonomy towards which South Africa is aiming.

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<sup>132</sup> S 2(1) of the Sterilization Act 44 of 1998.

<sup>133</sup> Ibid

<sup>134</sup> S 9(1) of the Mental Health Care Act 17 of 2002.

<sup>135</sup> S 9(1) of the Mental Health Care Act 17 of 2002.

*Castell v De Greef*<sup>136</sup> remains the definitive ruling on the standard of disclosure required for informed consent to medical treatment. Ackermann J held that a doctor is under a legal duty to obtain informed consent before a medical intervention. For consent to have been properly solicited, the patient must have knowledge of the nature and extent of harm or risk about to be entered, appreciate and understand nature of harm or risk about to be entered and he/she must consent to the harm or assume the risk. In addition the consent must be comprehensive and extend to the entire transaction<sup>137</sup>. Some of these elements also stated earlier have been codified in the NHA.

Furthermore, Ackermann J also states that the standard of disclosure requires only material risks to be disclosed. The risk is material if (a) a reasonable person in the plaintiff position would when warned of such risk attach significance to it (b) a medical practitioner is reasonably aware that a patient if warned of the risk would attach significance to it<sup>138</sup>. There is no duty to warn a patient about all the complications that may arise. However the doctor is advised to inform them about the more serious risks involved. The doctor need not inform the patient about all remote or unusual risk, but at minimum mention the probable or possible risks of harm especially when they are serious.

There are many cases that follow this approach such as *Louwrens v Oldwage*<sup>139</sup>, the court held that the defendant had explained in detail to the plaintiff the surgical procedures he planned to do which was eventually done. In the circumstances the plaintiff had given informed consent to the operation<sup>140</sup>. Risk to the plaintiff causing resultant harm was so negligible that it was not unreasonable or negligent of the defendant not to have mentioned it<sup>141</sup>. This decision did not rule out material risk criteria set out in the *Castell* case and thus courts are free to follow it<sup>142</sup>.

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<sup>136</sup> *Castell v De Greef* 1994 (4) SA 408 (C).

<sup>137</sup> *Castell v De Greef* 1994 (4) SA 408 (C) at 425.

<sup>138</sup> *Castell v De Greef* 1994 (4) SA 408(C) at 426.

<sup>139</sup> *Louwrens v Oldwage* 2006 (2) SA 161 (SCA).

<sup>140</sup> *Louwrens v Oldwage* 2006 (2) SA 161 (SCA) at 172.

<sup>141</sup> *Louwrens v Oldwage* 2006 (2) SA 161 (SCA) at 174.

<sup>142</sup> LC Coetzee & L Pienaar *Medical Law Study Guide* (2012) 102.

In *Esterhuizen v Administrator Transvaal*<sup>143</sup>, Bekker J intimated that a therapist who is not called in an emergency involving a matter of life or death should explain the situation and resultant dangers to the patient where he knows beforehand that the technique which he intends to employ could cause amputation, disfigurement and cosmetic changes<sup>144</sup>. The court found that the hospital and its doctors were liable after they had commenced deep radiation therapy on a child without her mother's consent which led to the loss of her right hand, two fingers on her left hand and both her legs<sup>145</sup>.

According to common law, the health professional is not entitled to depart materially from treatment agreed upon, especially where treatment is more radical than consented to by the patient<sup>146</sup>. However the doctor may be justified in extending the operation if: (a) its in accordance with good medical practice (b) takes place in good faith (c) risks to the patient is not materially increased and (d) it would be against medical interests to allow the patient to recover before giving consent. Extension usually occurs in cases of emergency on the basis of necessity<sup>147</sup>. In the *Stoffberg v Elliot case*<sup>148</sup>, during a surgical operation for which informed consent had been obtained, the surgeon undiagnosed cancer of the penis. Knowing that the patient would have a life expectancy of only two years, the doctor amputated the penis to prevent cancer from spreading. This was a material departure from treatment agreed upon and the court held that the patient was entitled to damages for assault as the removal was performed without specific consent.

It is important to note that a patient's refusal of treatment falls under the category of self-determination and such refusal should be respected. In the cases of *Palmer v Palmer*<sup>149</sup>, the personal guardianship of a husband over his wife does not give the husband a right to interfere with his wife's personal freedom to the extent that he can force her to undergo a medical examination against her will. Nor can the court make an order compelling the wife to undergo such operation at the behest of her husband, even

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<sup>143</sup> *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 (T).

<sup>144</sup> *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 (T) at 721.

<sup>145</sup> *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 (T) at 722.

<sup>146</sup> MA Dada & DJ McQuoid-Mason *Introduction to Medico-Legal Practice* (2001) 15.

<sup>147</sup> *Ibid*

<sup>148</sup> *Stoffberg v Elliot* 1923 CPD 148.

<sup>149</sup> *Palmer v Palmer* 1955 (3) SA 56 (O) 58.

though it might appear that such operation would be beneficial to the woman or the joint estate of herself and her husband.

## **2.7 INFORMED CONSENT AND ETHICS**

From an ethical dimension, autonomy forms the foundation of informed consent. As part of the legal right to self determination, autonomy involves having the freedom to exercise one's personal choice after being given all the relevant information, regardless of whether others approve of the choice being made<sup>150</sup>. It ensures patients are treated with respect and retain control over their own lives and bodies without interference from others according to his/her own reasons<sup>151</sup>. In this context of health care, autonomy means that every adult of a sound mind has the right to decide what shall be done to his/her body<sup>152</sup>. Autonomy has been given constitutional protection in the form of the right to life, dignity, privacy and bodily integrity<sup>153</sup>. Along with the constitution, there are policies and guidelines set out below amongst which autonomy is embedded.

### **2.7.1 Informed Consent and The Patients Rights Charter (Charter)**

The Charter recognizes the right to informed consent. It states that:

'Everyone has the right to be given full and accurate information about the nature of ones illness, diagnostic procedures, proposed treatment and cost involved for one to make a decision'<sup>154</sup>.

There is no reference to disclosure of risk as required by the NHA and common law, but such disclosure can be implied from the words 'full'. In fact the word 'full' goes further than the legal requirement of disclosure in the NHA and the material risk requirement in

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<sup>150</sup> R Thomas 'Where to from *Castell v De Greef*? Lessons from Recent Developments in South Africa and Abroad Regarding Consent to Treatment and the Standard of Disclosure' (2007) 124 *SALJ* 188, 205.

<sup>151</sup> JA Singh & C Ngweni 'Ethical Decision Making' in MA Dada & DJ McQuoid-Mason *Introduction Medio-Legal Practice* (2001) 33-34 .

<sup>152</sup> *Schloendorff v Society of New York Hospital* (1914) 105 NE 92.

<sup>153</sup> Thomas (note 112 above) 205.

<sup>154</sup> Patients Rights Charter available at <http://www.doh.gov.za/docs/legislation/patientsrights/chater.html>, accessed on 08 August 2014.

common law<sup>155</sup>. It is also clear from the above provision that every citizen has the right to participate in decision making matters affecting ones health<sup>156</sup>. It is therefore submitted that the Charter gives recognition to true patient autonomy.

### **2.7.2 Informed Consent and the Health Professions Council of South Africa**

#### **Guidelines (HPCSA)**

Patient's right to information regarding their health is envisaged in the HPCSA which doctors are urged to give patients information in a way they understand<sup>157</sup>. Clause 3.3 provides that the doctor should refrain from withholding any information, unless it is contrary to the patient best interest<sup>158</sup>. This will be discussed in chapter 3 in terms of therapeutic privilege. What constitutes sufficient information to be disclosed varies according to nature of the condition, complexity of treatment, risks associated and the patient's own wishes<sup>159</sup>. Booklet 9 illustrates that doctors are expected to allow patients to exercise their right to decide whether or not to undergo any medical intervention<sup>160</sup>. In the spirit of true autonomy, medical practitioners are reminded that even where a refusal may

result in harm or the patient's death, the patient still has a right to refuse<sup>161</sup>. Although these booklets have no legal force, it is submitted that they carry substantial evidentiary value of acceptable and reasonable practice in the provision of information regarding medical treatment.

## **2.8 LIABILITY FOR BREACH OF INFORMED CONSENT**

If the physician fails in his duty to obtain informed consent before proceeding with health services, such services will be regarded as unlawful and the medical practitioner or

<sup>155</sup> R Thomas 'Where to from *Castell v De Greef*? Lessons from Recent Developments in South Africa and Abroad Regarding Consent to Treatment and the Standard of Disclosure' (2007) 124 SALJ 188, 209.

<sup>156</sup> Patients Rights Charter available at <http://www.doh.gov.za/docs/legislation/patientsrights/chater.html> , accessed on 08 August 2014.

<sup>157</sup> HPCSA, *Seeking Patient's Informed Consent: The Ethical Consideration* Booklet 9: 2008, para 6.

<sup>158</sup> HPCSA, *Seeking Patient's Informed Consent: The Ethical Consideration* Booklet 9: 2008, para 3.3.

<sup>159</sup> HPCSA, *Seeking Patient's Informed Consent: The Ethical Consideration* Booklet 9: 2008, para 3.1.1.

<sup>160</sup> HPCSA, *Seeking Patient's Informed Consent: The Ethical Consideration* Booklet 9: 2008, para 2.3.

<sup>161</sup> R Thomas 'Where to from *Castell v De Greef*? Lessons from Recent Developments in South Africa and Abroad Regarding Consent to Treatment and the Standard of Disclosure' (2007) 124 SALJ 188, 205.

hospital is exposed to liability for civil or criminal assault, civil or *criminal inuria*, breach of contract or negligence<sup>162</sup>. Liability can ensue irrespective of whether the intervention proved to have benefited the patient and irrespective of whether it was performed with the necessary skill and care. In the case of *Stewart and Another v Botha*, the child was born with severe physical disabilities which led the father to sue the doctor who failed to detect the abnormalities and inform the child mother. The father also claimed that had the mother being properly informed she would have terminated the pregnancy and the child would not have being born at all. The court held that the doctor had a duty to inform the mother of the risks of having a deformed child in order to enable her to make an informed decision as to whether to abort the foetus<sup>163</sup>. Failure by the doctor left the doctor accountable for negligence.

## **2.9 EXCEPTIONS TO INFORMED CONSENT**

Certain circumstances justify a medical practitioner's medical intervention without obtaining the patient's prior consent. Thus in South African law such exceptions include: authorized court order or statutory authority, necessity (emergency), unauthorized administration, waiver and therapeutic privilege.

### **2.9.1 Compulsory Treatment**

Statutory authority and court order provisions in general apply to public health considerations. Government may infringe on an individual's rights in order to protect the interests of the public and society<sup>164</sup>. The treatment must be ordered for dangerous, mentally ill, patient with infectious diseases, alcohol or drug abusers, prisoners and pregnant women<sup>165</sup>. The best example to illustrate this exception is that it entitles medical officers to require person suspected on reasonable grounds of being carriers of communicable diseases to submit themselves to examination and treatment<sup>166</sup>. For

<sup>162</sup> Van Oosten '*Castell v De Greef* and the Doctrine of Informed Consent: Medical Paternalism Ousted in Favor of Patient autonomy' 1995 De Jure 164 ,178-179.

<sup>163</sup> *Stewart and Another v Botha and Another* 2007 (6) SA 247 (C) at 258.

<sup>164</sup> H Osman 'History and Development of the Doctrine of Informed Consent' (2001) 4 *International Electronic Journal of Health Education* 41 ,46.

<sup>165</sup> JW Berg *Informed Consent: Legal Theory and Clinical Practice* 2ed (2001) 90.

<sup>166</sup> Patrick van den Heever *Therapeutic Privilege in South African Medical Law* (unpublished LLM thesis, University



example, compulsory isolation maybe necessary in the case of XDR TB patients and considered as part of their treatment and preventing the spread of the disease. Often compulsory treatment follows refusal of treatment and therefore only applies if there is a valid court order or statute authorization and must be in the best medical interest of the patient<sup>167</sup>.

### **2.9.2 Emergency**

Necessity is also called 'emergency exception' which can occur in a hazardous situation or develop in the course of a medical procedure<sup>168</sup>. As a general rule, the doctor may render treatment without obtaining informed consent in matters of life and death, preventing serious irreparable mental or physical harm and alleviating pain and suffering. Also if the patient is not able to consent due to unconsciousness or an incapacity that resulted from the medical emergency, the physician is relieved from the responsibility of obtaining consent<sup>169</sup>. The rationale behind this exception is that the consent is implied by the situation. The law presumes that the person in distress would want to be treated even though he/she cannot explicitly consent<sup>170</sup>. Where there is strong evidence to the contrary, the physician may not override the patient's wishes<sup>171</sup>. However where the patient is incapable and his/her life is not at stake the physician is obligated disclose relevant information and seek consent from an appropriate proxy<sup>172</sup>.

### **2.9.3 Incompetence**

Incompetence also known as 'unauthorized administration' is whereby the patient is physically present, but psychologically absent. For example the patient must be in coma, unconscious, delirious, under anaesthetic, a minor, or his condition must be such that his awareness is affected to such degree that renders him/her incapable of taking care of their

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of Cape Town, 1997) 42.

<sup>167</sup> Berg (note 127 above) 90-91.

<sup>168</sup> Van den Heever (note 128 above) 48.

<sup>169</sup> Osman (note 126 above) 46.

<sup>170</sup> JG Malcolm *Treatment Choices and Informed Consent: Current Controversies in Psychiatric Malpractice Litigation* (1988) 89.

<sup>171</sup> JW Berg *Informed Consent: Legal Theory and Clinical Practice* 2ed (2001) 78.

<sup>172</sup> H Osman 'History and Development of the Doctrine of Informed Consent' (2001) 4 *International Electronic Journal of Health Education* 41, 46.

own interest and giving informed consent<sup>173</sup>. In such circumstances a surrogate or proxy is entitled to participate in the informed consent process on behalf of the patient to protect the interest of the patient<sup>174</sup>. The next of kin, parent or curator must be informed about relevant information in order for them to consent to medical intervention on behalf of the patient, provided it does not conflict with the best medical interest of the patient and does not justify medical intervention against the patient's will<sup>175</sup>.

#### **2.9.4 Waiver**

Where a patient waives his right to be informed, it indicates that the patient prefers not to be informed of the nature, risks and consequences of the treatment<sup>176</sup>. When the patient waives his right to receive information he/she is deciding either not to make their own medical decision by delegating it to someone else or to make his/her own medical decision, but to have it be uninformed or both<sup>177</sup>. Both situations affect the patient's decisional rights and therefore waiver should be voluntarily provided for and the medical practitioner should respect the wishes of the patient<sup>178</sup>.

#### **2.10 CONCLUSION**

As evidence from the above, it is clear that the doctor-patient relationship is a reciprocal relationship in that the doctor has a duty to disclose information and the patient has a right to receive such information. As a general rule, the disclosure allows the patient (or a person appointed on their behalf) to give informed consent to medical treatment/intervention emphasizing their right to self-determination and patient

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<sup>173</sup> Patrick van den Heever *Therapeutic Privilege in South African Medical Law* (unpublished LLM thesis, University of Cape Town, 1997) 50-51.

<sup>174</sup> Van den Heever (note 135 above) 50 ; Osman (note 134 above) 46.

<sup>175</sup> Van den Heever (note 135 above) 52-53.

<sup>176</sup> JG Malcolm *Treatment Choices and Informed Consent: Current Controversies in Psychiatric Malpractice Litigation* (1988) 90.

<sup>177</sup> Malcolm (note 138 above) 91 ; Osman (note 134 above) 46.

<sup>178</sup> Van den Heever (note 135 above) 56.

autonomy<sup>179</sup>. In other words, a medical practitioner may not interfere with the patient's physical or psychological integrity without first obtaining valid informed consent<sup>180</sup>. In the absence of obtaining consent, the doctor will be held liable<sup>181</sup>. However there are certain exceptions to the general rule, which justifies a medical practitioner's medical treatment/ intervention without obtaining a patient's prior informed consent which includes compulsory treatment, emergency, incompetence and waiver. The last and most important exception is therapeutic privilege which will be the focus in the following chapter.

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<sup>179</sup> M Beard & JR Midgley 'Therapeutic Privilege and Informed Consent : A justified Erosion of Patient Autonomy' (2005) 51 *THRHR* 51, 52.

<sup>180</sup> Patrick van den Heever *Therapeutic Privilege in South African Medical Law* (unpublished LLM thesis, University of South Africa, 2001) 2-3.

<sup>181</sup> Van Oosten 'Castell v De Greef and the Doctrine of Informed Consent: Medical Paternalism ousted in Favor of Patient Autonomy' 1995 *De Jure* 164, 178-179.



## **CHAPTER 3**

### **THERAPEUTIC PRIVILEGE IN THE SOUTH AFRICAN CONTEXT**

#### **3.1 DEFINITION OF THERAPEUTIC PRIVILEGE**

In exceptional circumstances a conflict ~~may often~~ arises between the doctors legal-ethical duty to inform the patient adequately in order to obtain informed consent (self-determination/autonomy) and his/her medical-ethical duty to protect the patient's well-being by reducing suffering (beneficence) and not cause harm to the patient (non-maleficence)<sup>1</sup>. Many doctors resort to therapeutic privilege as a conflict resolution. Therapeutic privilege has been correctly defined as:

"The doctor's discretion to withhold information from a patient regarding diagnosis, the nature of the treatment and risks involved when the doctor is of the opinion that the patient's state of mind is such that full awareness of the gravity and severity of his/her condition, or the drastic nature of treatment could be detrimental to such a degree that it will cause prejudice to his/her recovery"<sup>2</sup>.

Therapeutic privilege signifies an exception to informed consent and a legal defence in terms of which the doctor can justifiably withhold certain information from the patient to avoid harm to the patient<sup>3</sup>. Therefore one can say that therapeutic privilege aims at protecting patients who suffer from harmful effects of disclosure were to be made in accordance with the requirements of informed consent and it also frees the doctor from forcing them to violate their 'primary duty' to do what is beneficial for the patient and uphold the ethical obligation to do no harm<sup>4</sup>.

Below I will discuss how therapeutic privilege is recognised in our law in terms of the

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<sup>1</sup> D Welz 'The Boundaries of Medical Therapeutic Privilege' (1999) 116 *SALJ* 299, 300.

<sup>2</sup> P van den Heever 'Pleading the Defence of Therapeutic Privilege' (2005) 95 *SAMJ* 420, 420-421.

<sup>3</sup> Lodewicus Charles Coetzee *Medical Therapeutic Privilege* (unpublished LLM thesis, University of South Africa, 2001) 5.

<sup>4</sup> *Watson v Clutts* 136 SE 2d 617 (1964) 621.

constitution, legislation, common law, ethics and the contribution made by academic writers along with introducing the problems associated with the defence of therapeutic privilege.

### **3.2 THERAPEUTIC PRIVILEGE AND THE CONSTITUTION**

Section 36<sup>5</sup> provides a limitation clause to be used when two or more rights conflict. The right of self-determination/autonomy envisaged in section 12(2)(b) and (c) of the Constitution<sup>6</sup> must be weighed up against the ethical principles of beneficence and non-maleficence. A right can only be limited if it is reasonable and justifiable in an open and democratic society<sup>7</sup>. When considering whether the limitation is reasonable and justifiable the following factors must be taken into account: (i) the nature of the rights (ii) how important it is to limit the rights (iii) the nature of the limitation and its extent (iv) the relationship between the limitation and its purpose and (v) whether there are less restrictive means to achieve its purpose<sup>8</sup>.

~~Law that limits the rights in s12 are one of general application. Self-determination and autonomy are of general application because they apply to any person<sup>9</sup>. The question is whether limitation of self-determination/autonomy in s12(2)(b) and (c) for therapeutic privilege this right~~ maybe regarded as reasonable and justifiable ~~e in terms of the limitation clause~~. It is submitted that they may be limited –for the following reasons: (i) the nature of the right to self-determination and autonomy are not absolute rights especially in cases of court order, statute, emergency, incompetence and waiver<sup>10</sup> (ii) the ~~withholding of certain information~~ ~~limitation~~ is sufficiently important because it will prevent disclosure from causing more physical and psychological harm to the patient<sup>11</sup> (iii) the nature and extent of the limitation is such that it will only be limited to protect beneficence and non-maleficence and not to disregard the right of

<sup>5</sup> S 36 of the Constitution of the Republic of South Africa, 1996.

<sup>6</sup> S 12(2)(b) and (c) of the Constitution of the Republic of South Africa, 1996.

<sup>7</sup> S 36(1) of the Constitution of the Republic of South Africa, 1996.

<sup>8</sup> S 36(1)(a-e) of the Constitution of the Republic of South Africa, 1996.

<sup>9</sup> S 36(1) of the Constitution of the Republic of South Africa, 1996.

<sup>10</sup> S 36(1)(a) of the Constitution of the Republic of South Africa, 1996.

<sup>11</sup> S 36(1)(b) of the Constitution of the Republic of South Africa, 1996.

self-determination/autonomy completely so as to violate the patients fundamental rights relating to security in and control over their body<sup>12</sup> (iv) the limitation is rationally connected to the purpose of protecting the patient's health and recovery (beneficence) and ensure that the patient's recovery will not be prejudiced by the disclosure of information (non-maleficence)<sup>13</sup> (v) the limitation restricts the right to self-determination/autonomy as little as possible in that it can be interpreted to mean that doctors can only withhold information where he/she is of the opinion that such disclosure will not benefit the patient and cause them more harm in terms of recovery<sup>14</sup>. Therefore the doctor is allowed to limit the patients right of self-determination/autonomy by withholding information. Such limitation is only reasonable and justifiable if its in the best interest of the patient. ~~herefore it would be reasonable and justifiable to limit the patient's right to self-determination/autonomy and allow for the doctor to withhold information.~~

### **3.3 THERAPEUTIC PRIVILEGE AND THE NATIONAL HEALTH ACT (NHA)**

Section 6(1)(a)<sup>15</sup> states that every health care provider must inform the user of their health status except in circumstances where the disclosure of the user's health status would be contrary to the best interest of the user. This amounts to a statutory version of therapeutic privilege. Furthermore section 8(3) of the NHA also indicates such recognition. It stipulates that if the user is unable to participate in the decision affecting his/her health and treatment, they must be informed after the provision of health services, unless such disclosure will be contrary to the user's best interests<sup>16</sup>.

The problem with regard to legislation is that it does not stipulate the precise circumstances in which it will be in the patient's best interests to invoke the defence of therapeutic privilege.

### **3.4 THERAPEUTIC PRIVILEGE AND COMMON LAW**

<sup>12</sup> S 36(1)(c) of the Constitution of the Republic of South Africa, 1996.

<sup>13</sup> S 36(1)(d) of the Constitution of the Republic of South Africa, 1996.

<sup>14</sup> S 36(1)(e) of the Constitution of the Republic of South Africa, 1996.

<sup>15</sup> S 6(1)(a) of the National Health Act 61 of 2003.

<sup>16</sup> S 8(3) of the National Health Act 61 of 2003.

There has been a few *obiter dictums* in South Africa which maybe seen as the starting point for the defence of therapeutic privilege. In the *SA Medical and Dental Council v McLoughlin* case<sup>17</sup>, Watermeyer CJ held that it is sometimes advisable for a medical practitioner to keep secret from his patient the treatment which he/she is giving the patient. In the 1976 case of *Richter v Estate Hammann*<sup>18</sup>, Watermeyer J remarked that the doctors are faced with a dilemma because if they fail to disclose the risks, he/she may render himself/herself liable for assault, whereas if he/she discloses the risks they may well frighten the patient into not having the operation which would be in the patient's best interest. This remark by Watermeyer J led to the defence of therapeutic privilege being built<sup>19</sup>.

In the 1994 case of *Castell v De Greef*<sup>20</sup>, Mrs C developed complications during removal of breast tissue and reconstruction of her breast. She filed a lawsuit against the doctor claiming that he failed to advise her of the 50% chance of risk of complications and that an alternative surgical procedure existed that could have reduced any risks. The court held that the doctor had not quantified the degree of risk of complications, but this was not a material non-disclosure. He was however negligent in not taking a pus swab when the patient developed an infection. As a result he treated her with an antibiotic to which the organism causing the infection was resistant. Mrs C was compensated for 12 days of pain, illness, discomfort and anxiety. In the course of his judgment, specifically in *obiter* Ackermann J noted that the obligation to warn patients of the material risks is subject to therapeutic privilege 'whatever its ambit of the so called therapeutic privilege may today still be'. The court acknowledged the existence of the defence of therapeutic privilege but declined to explore its parameters<sup>21</sup>.

The problem that lies with common law is that despite its recognition, therapeutic privilege has not been applied in any reported decisions in South African law. It has only

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<sup>17</sup> *SA Medical & Dental Council v McLoughlin* 1948 (2) SA 355 (A) at 366.

<sup>18</sup> *Richter v Estate Hammann* 1976 (3) SA 226 (C) at 232.

<sup>19</sup> D Welz 'The Boundaries of Medical Therapeutic Privilege' (1999) 116 *SALJ* 299, 299.

<sup>20</sup> *Castell v De Greef* 1994 (4) SA 408 (C).

<sup>21</sup> *Castell v De Greef* 1994 (4) SA 408 (C) at 426-427.



being mentioned *obiter* in cases such as *SA Medical and Dental Council v McLoughlin* and *Castell v De Greef*. Leaving open the question of what 'the ambit of the so-called privilege may be'.

### **3.5 THERAPEUTIC PRIVILEGE AND THE HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA (HPCSA)**

Health care practitioners should not withhold information necessary for decision making, unless they judge that disclosure would cause the patient serious harm<sup>22</sup>. In this context serious harm does not mean the patient would become upset or decide to refuse treatment<sup>23</sup>. If the patient asks the medical practitioners to withhold information or nominates a person to make decisions on their behalf, the practitioner should explain to the patient the importance of knowing options available to them and what the treatment they may receive will involve<sup>24</sup>. If the patient insists on not being told information in detail about their condition or treatment, the practitioner should still provide basic information<sup>25</sup>. If a relative ask the practitioner to withhold information, the practitioner should seek the views of the patient<sup>26</sup>. Further the HPCSA makes reference to the NHA in recognizing disclosure to patients, unless it would be contrary to the patient's best interest<sup>27</sup>.

Similar to the NHA, the HPCSA does not define the boundaries of when it will be in the patient's best interest to withhold information using the defence of therapeutic privilege.

### **3.6 THERAPEUTIC PRIVILEGE AND ETHICS**

<sup>22</sup> HPCSA *Seeking Patient's Informed Consent: The Ethical Considerations* Booklet 9: 2008, para 3.3.1.

<sup>23</sup> HPCSA *Seeking Patient's Informed Consent: The Ethical Considerations* Booklet 9: 2008, para 3.3.1.

<sup>24</sup> HPCSA *Seeking Patient's Informed Consent: The Ethical Considerations* Booklet 9: 2008, para 3.3.3.

<sup>25</sup> Ibid

<sup>26</sup> HPCSA *Seeking Patient's Informed Consent: The Ethical Considerations* Booklet 9: 2008, para 3.3.3.

<sup>27</sup> HPCSA *Seeking Patient's Informed Consent: The Ethical Considerations* Booklet 9: 2008, para 3.3.4.

The main principle in ethics is that when therapeutic privilege is invoked, beneficence and non-maleficence causes the right of autonomy to be limited<sup>28</sup>. Beneficence is understood to cover acts of kindness, maximizing possible benefits and minimizing possible harm<sup>29</sup>. The Hippocratic Oath requires physicians to benefit their patients according to their best interests<sup>30</sup>. Non-maleficence includes not deliberately harming the patients<sup>31</sup>. When the disclosure would be harmful to the patient and not in his/her best interest, the practitioner is allowed to justify non-disclosure using the defence of therapeutic privilege thus upholding the Hippocratic Oath.

The principle of justice speaks to the belief that we should all be treated equally<sup>32</sup>. In other words all patients should be treated alike. It is not inconceivable that these principles may conflict with one another<sup>33</sup>. One principle must thus be judged as having priority over the other<sup>34</sup>. For example if justice requires disclosure to all patients, despite such disclosure causing physical or psychological harm to the patient's health. In this example the principles of beneficence, non-maleficence and justice are in irreconcilable conflict with each other. It would be fair to make disclosure to those who are able to make rational decisions based on the information disclosed and not to those whom disclosure would prejudice their recovery. In this way beneficence and non-maleficence prevails and the doctor acts in the patient's best interest and avoids causing harm thus upholding the Hippocratic Oath.

### 3.7 THERAPEUTIC PRIVILEGE AND ACADEMIC WRITERS

It is trite that the psychological profile of the patient is an integral part when evaluating

<sup>28</sup> D Welz 'The Boundaries of Medical Therapeutic Privilege' (1999) 116 *SALJ* 299, 304 ; see para 3.2 above.

<sup>29</sup> JA Singh & C Ngwena 'Ethical Decision Making' in MA Dada & DJ McQuoid-Mason *Introduction to Medio-Legal Practice* (2001) 33.

<sup>30</sup> JA Singh & C Ngwena 'Ethical Decision Making' in MA Dada & DJ McQuoid-Mason *Introduction to Medio-Legal Practice* (2001) 33. ~~Ibid~~

<sup>31</sup> ~~Ibid~~ Singh & Ngwena (note 29 above) 33.

<sup>32</sup> JA Singh & C Ngwena 'Ethical Decision Making' in MA Dada & DJ McQuoid-Mason *Introduction to Medio-Legal Practice* (2001) 34.

<sup>33</sup> Ibid

<sup>34</sup> JA Singh & C Ngwena 'Ethical Decision Making' in MA Dada & DJ McQuoid-Mason *Introduction to Medio-Legal Practice* (2001) 34. ~~Singh & Ngwena (note 32 above) 34.~~

the consequences if full disclosure is made to an already compromised patient<sup>35</sup>. Writers such as Patrick van den Heever<sup>36</sup> stated that the medical practitioner should as a requirement make a clinical assessment of the patient's psychological status on presentation of the complaint. If the clinical assessment is indicative that full disclosure may have adverse effects for the patient, it is suggested that the practitioner should 'test' the patient by imparting information of a general nature in a sensitive and compassionate manner to the patient in an attempt to evaluate the patient's understanding and emotional reaction to the information conveyed to him/her<sup>37</sup>. The medical practitioner will also be assisted by taking into account the patient's medical history in terms of the effects of disclosures by other medical practitioners who were involved in the treatment or management of the patient is also relevant<sup>38</sup>.

Patrick van den Heever states that the defence of therapeutic privilege in civil actions will have to be pleaded and proved by the medical practitioner<sup>39</sup>. In other words the onus of justifying the non-disclosure vests with the medical practitioner involved. The practitioner must be able to prove the existence of a direct *nexus* between the nature of the medical intervention or diagnosis and extent of non-disclosure<sup>40</sup>. A more serious intervention or diagnosis should pose a higher risk or threat of psychological or physical harm to the patient and will be an important factor for the court to evaluate when it considers the reasonableness of the non-disclosure<sup>41</sup>.

Patrick van den Heever further states that in complying with the clinical assessment, clinical note keeping assists the medical practitioner in justifying his defence of relying on therapeutic privilege, the physician should document the following information: (i)

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<sup>35</sup> P van den Heever 'Pleading the Defence of Therapeutic Privilege' (2005) 95 *SAMJ* 420, 420 ; Patrick van den Heever *Therapeutic Privilege in South African Medical Law* (unpublished LLM thesis, University of Cape Town, 1997) 136.

<sup>36</sup> *Ibid*

<sup>37</sup> P van den Heever 'Pleading the Defence of Therapeutic Privilege' (2005) 95 *SAMJ* 420, 420 ; Patrick van den Heever *Therapeutic Privilege in South African Medical Law* (unpublished LLM thesis, University of Cape Town, 1997) 136.

<sup>38</sup> P van den Heever 'Pleading the defence of therapeutic privilege' (2005) 95(6) *SAMJ* 420, 420 ; Patrick van den Heever *Therapeutic privilege in South African medical law*(unpublished LLM thesis, University of Cape Town , 1997) 136

<sup>39</sup> P van den Heever 'Pleading the Defence of Therapeutic Privilege'(2005) 95 *SAMJ* 420, 421 ; Patrick van den Heever *Therapeutic Privilege in South African Medical Law* (unpublished LLM thesis, University of Cape Town, 1997) 137.

<sup>40</sup> P van den Heever 'Pleading the Defence of Therapeutic Privilege' (2005) 95 *SAMJ* 420, 420 ; Patrick van den Heever *Therapeutic Privilege in South African Medical Law* (unpublished LLM thesis, University of Cape Town, 1997) 137.

<sup>41</sup> *Ibid*

details of the patients medical history, psychological profile and details of the clinical assessment (ii) the nature of the diagnosis or diseases, its course or prognosis (iii) the material risks and/or complication associated with the treatment with reference to the risks that will remain undisclosed (iv) the extent for the medical practitioners non-disclosure (v) the reasons for non-disclosure (vi) the nature of the harm and the detrimental effect which the medical practitioner recognized and sought to avoid<sup>42</sup>. These records will constitute *prima facie* proof of the medical practitioner reasons of non-disclosure and could allow the medical practitioner to escape liability for non-disclosure<sup>43</sup>.

It is evident that academic writers have provided guidance regarding the defence, as the legislature and the courts do not offer much help. Despite the fact that there are many legal opinions suggesting requirements that have to be met by practitioners indicating its essentiality to justify the invocation of the defence and escape liability. However none has been included in South African legislation and case law.

### **3.8 THE REASONABLE PATIENT STANDARD FOR NON-DISCLSOURE**

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As we have seen above therapeutic privilege gives doctors a wide discretion to act in a paternalistic manner which is rejected by much case law, specifically *Castell v De Greef*. In the judgment of the court a quo in the case of *Castell v De Greef*, Scott J found the 'reasonable doctor' test afforded flexibility<sup>44</sup>. The reasonable doctor test was rejected in *Castell v De Greef (1994) (4) SA 408 (C)* because it found no judicial pronouncement in South Africa to the effect that disclosure had been unnecessary because a reasonable doctor would not have warned the patient. Therefore the court found it a necessity to introduce a patient-orientated approach to disclosure.

With regard to the patient-orientated approach there are two patient standards which can

<sup>42</sup> P van den Heever 'Pleading the Defence of Therapeutic Privilege' (2005) 95 *SAMJ* 420, 420; Patrick van den Heever *Therapeutic Privilege in South African Medical Law* (unpublished LLM thesis, University of Cape Town, 1997) 137 ~~Van den Heever (note 39 above)~~

<sup>43</sup> P van den Heever 'Pleading the Defence of Therapeutic Privilege' (2005) 95 *SAMJ* 420, 421; Patrick van den Heever *Therapeutic Privilege in South African Medical Law* (unpublished LLM thesis, University of Cape Town, 1997) 138.

<sup>44</sup> *Castell v De Greef* (1993) (3) SA 501 (C) at 517J-518B

be applied, namely the objective or reasonable patient standard based on informational requirements of a hypothetical reasonable patient or the subjective patient standard whereby the medical practitioner must disclose information which he knows or ought to know that his patient in a particular situation requires<sup>45</sup>.

The objective standard means the patient's right to decide what is to be done with his/her body is made subject to a standard set by others. The difficulty with this is that how do courts determine the standards of a hypothetical patient<sup>46</sup>. It gives rise to the fear that only medical evidence will be relied on. If the patient subjective values are ignored then there is little difference between the objective standard and a standard which is set solely by reference to medical opinion<sup>47</sup>. The subjective standard is also rejected based on the premise that it imposes a too-onerous obligation on medical practitioners and exposes them to patient hindsight<sup>48</sup>.

After considering the various approaches the court in *Castell v De Greef*<sup>49</sup> approved of the reasonable patient test as a point of departure supplemented by a more subjective patient-based standard which allows for situations beyond the parameters of the objective test. Therefore the court found that the medical practitioner is obliged to warn the patient of material risk and such risk is material if a reasonable person in the patient's position if warned of such risk would attach significance to it and the medical practitioner should be reasonably aware that the patient if warned would attach significance to it<sup>50</sup>.

The reasonable patient test is also should also be applicable to therapeutic privilege. A doctor cannot withhold information if and when he/she feels like. He/She may only do so if according to the reasonable patient standard it would be in the patient's best interest not

<sup>45</sup> *Castell v De Greef* (1994)(4) SA 408(C) at 421

<sup>46</sup> P Van den Heever *Therapeutic Privilege in South African Medical Law* (Unpublished LLM thesis, University of Cape Town, 1997) 38-39; P Van den Heever 'The Patient's Right to Know: Informed Consent in South African Law' 1995 *De Rebus* 53, 53-56

<sup>47</sup> P Van den Heever *Therapeutic Privilege in South African Medical Law* (Unpublished LLM thesis, University of Cape Town, 1997) 38-39; P Van den Heever 'The Patient's Right to Know: Informed Consent in South African Law' 1995 *De Rebus* 53, 53-56

<sup>48</sup> *Ibid*

<sup>49</sup> *Castell v De Greef* (1994) (4) SA 408 (C) at 426

<sup>50</sup> *Castell v De Greef* (1994) (4) SA 408 (C) at 425

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to disclose certain information. This is why the courts would still allow a patient's right to full disclosure to be limited. This formulation also sets its face against medical paternalism from being reiterated and which SA is moving away from.

### **3.98 CONCLUSION**

From the above discussion, it is evident that therapeutic privilege is legally and ethically recognised in our law as a defence to non-disclosure. Although the contours of therapeutic privilege are uncertain, its purpose is clear in that it aims to justify physicians from not complying with the legal requirement of informed consent, which forces them to violate the ethical principles of beneficence and non-maleficence. The courts do allow therapeutic privilege if according to the reasonable patient standard it would be in the patient's best interest not to know certain information as it will cause more harm to them. Nevertheless There are three research problems that still exist here.

Firstly, there is a lacuna in South African law in terms of legislature, in that they do not stipulate the precise circumstances in which it will be in the patient's best interest to invoke the defence of therapeutic privilege by the medical practitioner. Secondly, South African courts do not expand on the ambit and parameters of therapeutic privilege, therefore the precise nature and role in non-disclosure instances remain uncertain. Thirdly, despite the useful guidance by writers there still exists an absence of prescribed requirements in law that have to be met by the medical practitioner in order to justify the defence and escape liability for non-disclosure.

The main question in this regard is: 'when is therapeutic privilege legally/not legally justified?' Therefore the following chapter focuses on the principles to be adopted from common law countries with regard to the precise circumstances and specific requirements that have to be satisfied in order for the defence to be legally justified.

## CHAPTER 4

### JUDICIAL FORMULATIONS OF THERAPEUTIC PRIVILEGE IN COMMON LAW COUNTRIES

#### 4. INTRODUCTION

The following principles are to be referred to because they offer useful guidance to the South African legislature and courts or incorporate such principles into our legal system because it bears similarity to the South African medical principles.

##### 4.1 United Kingdom

###### 4.1.1 Common Law and its Common Law

In the case of *Sidaway v Board of Governors of Bethelhem Royal Hospital and the Maudsley Hospital*<sup>1</sup>, ~~the~~ plaintiff in this case alleged negligence by the surgeon for failing to disclose or explain to her the risks inherent in the operation. The defence raised was therapeutic privilege. The court recognized therapeutic privilege ~~as an exception to informed consent~~. Such ~~defence exception~~ enables the doctor to withhold information such as the risks from the patient, especially if it can be shown from a reasonable assessment of the patient that disclosure would have posed a serious threat of psychological detriment to the patient<sup>2</sup>. The court further held that the doctor may escape liability for failing to warn the patient of material risk if he can illustrate that he genuinely believed that communication of such risk would be detrimental to the health (including mental health) of his patient<sup>3</sup>. In other words, Lord Scarman required the physician to advance and prove his defence of therapeutic privilege by referring to medical evidence concerning the patient circumstances<sup>4</sup>.

<sup>1</sup> *Sidaway v Board of Governors of Bethelhem Royal Hospital and the Maudsley Hospital* [1985] All ER 643 (HL).

<sup>2</sup> *Sidaway v Board of Governors of Bethelhem Royal Hospital and the Maudsley Hospital* [1985] All ER 643 (HL).  
at 653.

<sup>3</sup> *Sidaway v Board of Governors of Bethelhem Royal Hospital and the Maudsley Hospital* [1985] All ER 643 (HL).  
at 654

<sup>4</sup> *Ibid*

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The *Sidaway* case is useful because it provides the principle that therapeutic privilege is justified in cases where disclosure of risks would pose a serious threat of psychological (mental health) detriment to the patient's health. In order to justify the defence and escape liability the physician must prove that non-disclosure was based on a reasonable clinical assessment by referring to medical evidence.

Dunn LJ stated in the case of *Sidaway*<sup>5</sup> that informed consent forms no part in English law. He is referring to the subjective patient approach. Disclosure depends on what the patient needs to know. Technically English law does not have a concept of informed consent except in the very limited form. In *Chatterton v Gerson*<sup>6</sup> it was held that the patient only needs to be informed in broad terms of the nature of the procedure intended. Again Lord Donaldson in *Re T*<sup>7</sup> held that English law does not accept the concept of informed consent and disclosure of information would vary from patient to patient. This suggests that it is still the medical profession which decides how much a patient should be told in order to make a decision.

On a comparative note, the USA, Australia and Canada have a concept of informed consent which looks to what a reasonable patient in the plaintiff's position would consider significant enough to warrant disclosure in order to make an informed decision. In other words it focuses on the needs of the patient rather than what the doctor considers the patient needs to know.

#### 4.1.2 Legislation

The National Service Act<sup>8</sup> accounts for the best interest of the patient and is similar to the Data Protection Act<sup>9</sup> in SA in that it allows a patient to require the health care practitioner to provide personal data of which he/she is a data subject. The health care practitioner is allowed to restrict access to such information if disclosure is likely to cause

<sup>5</sup> *Sidaway v Board of Governors of Bethelhem Royal Hospital and the Maudsley Hospital* [1985] All ER 643 (HL).

<sup>6</sup> *Chatterton v Gerson* [1981] QB 432

<sup>7</sup> *Re T (adult) (Refusal of Medical Treatment)* [1992] 4 ALL ER 649. P663; [1992] 9 BMLR 46, p61

<sup>8</sup> National Health Service Act 1997

<sup>9</sup> Data Protection Act C9 Part II section 10(1)(a) and (b)

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substantial damage or distress to the patient and such damage or distress would be unwarranted<sup>10</sup>.

It is therefore justified that information concerning treatment can be withheld if it is reasonably established that disclosure would cause psychological harm to the patient. The National Health Service Act<sup>11</sup> further states that access can be withheld if it would cause physical or mental harm to the patient. Withholding such information should not be done lightly and should be well justified and documented.

## **4.2 United States of America**

### **4.2.1 Common Law**

In the case of *Canterbury v Spence*<sup>12</sup>, the plaintiff initially consulted the defendant because of severe pain between the shoulder blades. The defendant told the plaintiff that he needed to undergo a laminectomy to correct what he suspected was a ruptured disc. The defendant did not tell the plaintiff details about the operation. The plaintiff being 19 at the time did not object or inquire about the implications involved in the operation. The defendant had explained to the plaintiff's mother that the laminectomy was not more serious than other operations. However the laminectomy revealed problems which the defendant sought to treat, but subsequently the plaintiff suffered a number of permanent disabilities which he alleged arose from the laminectomy. The plaintiff sued the defendant for negligence in performing the laminectomy and for failure to inform him of the risks involved in the operation. The defendant argued that communication of risk to the patient would not have been good medical practice as it might produce adverse psychological reactions which could preclude success of the operation. He relied on the defence of therapeutic privilege.

In this case, Robinson J recognized the physician's therapeutic privilege in circumstances

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<sup>10</sup> National Health Service Act 1997

<sup>11</sup> National Health Service Act 1997

<sup>12</sup> *Canterbury v Spence* 464 F2d 772 (1972) (DC Cir).

where risk disclosure causes the patient to become so ill or emotionally distraught rendering them unable to make a rational decision or their decision will complicate or hinder treatment or even pose a psychological damage to the patient<sup>13</sup>. In these instances the physician is able to use the privilege to withhold information from the patient.

The privilege to withhold information does not include the paternalistic notion that the doctor may remain silent simply because divulgence might prompt the patient to forgo the intervention which the doctor feels the patient really needs<sup>14</sup>. The physician would be justified in invoking the defence of therapeutic privilege if he can show that he responded to a sound medical judgment that communication of risk would present a threat to the patient's well being<sup>15</sup>.

Further the court emphasized the patient's right to self-determination and autonomy and found that disclosure would only be warranted where the physician regarded the patients reaction would be 'menacing' upon disclosure<sup>16</sup>. Therefore the court suggested that disclosure under these circumstances be made to a close relative to satisfy the requirement of consent<sup>17</sup>.

This case is important in that it provides the principle that therapeutic privilege will be justified in cases where disclosure of risk causes the patient to become so ill or emotionally distraught leaving them unable to make a rational decision or if they do, such decision may complicate or even hinder treatment. The physician can justify the defence and escape liability if he can prove a that non-disclosure was based on sound medical judgment which arouse from a clinical assessment.

In *Roberts v Wood*<sup>18</sup>, the plaintiff alleged that she was insufficiently advised as to the seriousness of the operation. Thomas J remarked that he could not fault the practice

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<sup>13</sup> *Canterbury v Spence* 464 F2d 772 (1972) (DC Cir) at 788-789.

<sup>14</sup> *Canterbury v Spence* 464 F2d 772 (1972) (DC Cir) at 788-789.

<sup>15</sup> *Canterbury v Spence* 464 F2d 772 (1972) (DC Cir) at 788-789.

<sup>16</sup> *Canterbury v Spence* 464 F2d 772(1972) (DC Cir) at 789.

<sup>17</sup> *Ibid*

<sup>18</sup> *Roberts v Wood* 206 F Supp 579 (D Ala 1962).

where medical practitioners frequently tailor the extent of their pre-operative disclosures to the patient<sup>19</sup>. This is due to the fact that much of the risks is of a technical nature beyond the patient's understanding and the anxiety, apprehension and fear generated by a full disclosure may have a very detrimental effect on the patient<sup>20</sup>.

This case is crucial as it provides the principle that therapeutic privilege is justified in cases where disclosure of risks would have an adverse effect on the patient's health causing them to experience more anxiety, apprehension and fear.

In *Cobbs v Grant*<sup>21</sup>, the court recognized therapeutic privilege by intimating that if a doctor could prove that he/she relied upon facts which would demonstrate that disclosure would have seriously upset the patient causing the patient not to be able to dispassionately weigh the risks of refusing to undergo treatment<sup>22</sup>. In such instances disclosure would not have to be made and the doctor would be justified in his defence of therapeutic privilege<sup>23</sup>.

This case is essential because it provides the principle that therapeutic privilege is justified in cases where disclosure of risks renders the patient incapable of balancing the advantages and disadvantages of rejecting treatment because such disclosure has seriously upset the patient.

In the case of *Wilkinson v Vesey*<sup>24</sup>, Mrs Winifred Wilkinson experienced radiating pains in her hands, arms and legs. She had an X-ray taken of her chest which revealed a shadow. She was then recommended by Dr Hunt and Dr Vesey to undergo a trial course of deep radiation therapy. The defendants diagnosed the plaintiff's ailment as a malignant tumor in the right upper mediastinum. Constant x-rays were taken of the chest and back to see the progress of radiation therapy conducted on her chest and back. Mrs Winifred began to

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<sup>19</sup> *Roberts v Wood* 206 F Supp 579 (D Ala 1962) at 583.

<sup>20</sup> *Roberts v Wood* 206 F Supp 579 (D Ala 1962) at 583. ~~*Roberts v Wood* 206 F Supp 579 (D Ala 1962) at 583.~~

<sup>21</sup> *Cobbs v Grant* 104 Cal Rptr 505 (1972).

<sup>22</sup> *Cobbs v Grant* 104 Cal Rptr 505 (1972).

<sup>23</sup> *Ibid*

<sup>24</sup> *Wilkinson v Vesey* A 2d 676 (RI 1972).

notice discoloration of the chest area, skin break down and her back area began to deteriorate. She then sued the defendants for failing to inform her of the risks associated with the treatment and therefore failed to obtain her knowing consent.

Justice Kelleher recognized the role of therapeutic privilege when he stated that a physician is required to disclose risks inherent upon a proposed medical intervention, unless the doctor can prove that non-disclosure was in the best interest of the patient. It would be in the best interest of the patient when the disclosure of risks would unduly agitate or undermine an unstable patient<sup>25</sup>.

This case is imperative as it provides the principle that therapeutic privilege is justified in cases where the patient would become unduly agitated by the disclosure of risks or such disclosure would seriously undermine an unstable patient.

In the case of *Tatro v Leuken*<sup>26</sup>, Justice Kaul found that a physician may withhold information from a patient if he/she finds that complete disclosure would endanger the recovery of the patient because of their existing physical or mental condition<sup>27</sup>.

This case is influential because it provides the principle that therapeutic privilege is justified in cases where an existing physical or mental condition may be worsened by full disclosure.

In the case of *Cornfeldt v Tongen*<sup>28</sup>, Phyllis Cornfeldt underwent surgery for a perforated gastric ulcer. The defendant Dr Tongen repaired the lesion and ordered examination of suspicious tissue surrounding the ulcer. An analysis indicated cancer and therefore Dr Tongen recommended removal of the cancerous portion of the stomach. Two routine pre-operative blood tests conducted revealed liver malfunction. However Dr Tongen proceeded with the cancer surgery despite the results and without mentioning the

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<sup>25</sup> *Wilkinson v Vesey* A 2d 676 (RI 1972) at 686.

<sup>26</sup> *Tatro v Leuken* Kan 512 P2d (Kan 1973).

<sup>27</sup> *Tatro v Leuken* Kan 512 P2d (Kan 1973) at 537.

<sup>28</sup> *Cornfeldt v Tongen* 262 N.W. 2d 684 (Minn 1977).

increased risks they represented to Mrs Confeldt. Several days after, Mrs Cornfeldt developed jaundice. Her condition continued to deteriorate and she died as a result of liver failure. The plaintiff's descendant brought an action against the defendant for being negligent in failing to inform the plaintiff of the increased risks indicated by the test results hence failing to obtain proper informed consent.

Judge Kelly recognized therapeutic privilege as an exception to disclosure, which excuses non-disclosure where such would be unhealthful to the patient<sup>29</sup>. Further Kelly J held that therapeutic privilege can only be invoked if disclosure of the information would complicate or hinder treatment, cause such emotional distress as to exclude a rational decision or cause psychological harm to the patient<sup>30</sup>.

This case is meaningful as it provides the principle that therapeutic privilege is justified in cases where disclosure of risks would have a adverse effect on the patient causing them to experience emotional distress and not being able to make a rational decision.

In North Dakota the court per Pederson J held in *Wasem v laskowski*<sup>31</sup> that a doctor should not be obliged to disclose extremely remote and rare risks which in some circumstances may only tend to falsely or detrimentally alarm the particular patient<sup>32</sup>.

This case is vital in that it provides that therapeutic privilege is justified in cases where the risks are far-fetched and unlikely to occur. If disclosed it may unnecessarily be detrimental to the patient.

In *Harnish v Children's Hospital Medical Centre*<sup>33</sup>, the plaintiff underwent a surgery to remove a tumor from the neck. In the course of her procedure her hypoglossal nerve was severed, allegedly resulting in the critical loss of certain functions of her tongue. She

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<sup>29</sup> *Cornfeldt v Tongen* 262 N.W. 2d 684 (Minn 1977). ~~Ibid~~

<sup>30</sup> *Cornfeldt v Tongen* 262 N.W. 2d 684 (Minn 1977).

<sup>31</sup> *Wasem v Laskowski* 274 NW 2d 219 (ND 1979).

<sup>32</sup> *Wasem v Laskowski* 274 NW 2d 219 (ND 1979) at 226.

<sup>33</sup> *Harnish v Children's Hospital Medical Centre* Mass 439 N.E. 2d 245 (Mass 1982).

brought an action contending that the purpose of her procedure was cosmetic and the resulting injury was foreseeable. She maintained that if she had been apprised of the risks involved in the surgery she would not have consented to the procedure. Thus she asserted that the physicians who treated her did not properly inform her of the possible consequences and therefore should be held liable.

At the same time the court recognized a privilege of non-disclosure under certain circumstances and found that the burden of proof lies with the physician to justify the defence of non-disclosure<sup>34</sup>.

This case is of paramount importance as it illustrates the requirement that the onus of justifying invocation of the defence and escaping liability lies with the physician himself. This requirement is none other than the clinical assessment.

#### 4. 2. 2 Legislation

Certain legislatures in the United States of America have incorporated some form of therapeutic privilege in their legislation. According to the New York Public Health Law<sup>35</sup>, a health care provider uses reasonable discretion as to the manner and extent to which alternatives or risks are disclosed to the patient, because he reasonably believed the manner and extent of such disclosure could reasonably be expected to substantially affect the patient's condition. The Texas Health and Safety Code<sup>36</sup> provides that information can be withheld where for some or other reason (than emergency) it was not medically feasible to make disclosure. Lastly in Vermont, the legislation was similar to that of the New York Public Health Law. It was held that a reasonable medical practitioner would withhold information because the manner and extent of such disclosure could reasonably be expected to adversely and substantially affect the patient's condition, in which case the medical practitioner should provide the information to a member of the immediate family

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<sup>34</sup> *Harnish v Children's Hospital Medical Centre* Mass 439 N.E. 2d 245 (Mass 1982) at 244.

<sup>35</sup> New York Public Health Law 2805-d(4)(d).

<sup>36</sup> Texas Health and Safety Code Title 71 Art 4590 i 6.07 (a)(2).

if reasonably available<sup>37</sup>.

These legislation are significant in that it provides that therapeutic privilege will be justified in circumstances where disclosure would have an extensive, adverse effect on the patient's condition. In order for the physician to justify the defence and escape liability, he/she is required to prove that disclosure would not be medically reasonable and feasible.

### 4.3 Australia

#### 4.3.1 ~~and its~~ Common Law

In *F v R*<sup>38</sup>, a married woman required a sterilization operation to avoid further pregnancies. However she was advised by the medical practitioner to have a tubal ligation instead. The operation was performed but subsequently the woman fell pregnant. She alleged that the practitioner failed to inform her that tubal ligation have a failure rate of less than one percent. King J reassured the fact that doctors are justified in withholding information in circumstances where full disclosure of risk will seriously harm the patient's health whether it is physical or mental<sup>39</sup>.

The court also found that non-disclosure may exist when the doctor reasonably is of the opinion that a patient's temperament is such that he /she would be unable to make the information which he receives the basis for a rational decision<sup>40</sup>.

This case is relevant because it states that considerations relating to the serious harm caused to the patient is necessary when reaching a decision whether to make disclosure. Therapeutic privilege is therefore justified when the patient's physical or mental health is at stake by disclosure. Furthermore if disclosure affects the patient's temperament which renders them incapable of making a logical decision based on the information disclosed to them, then non-disclosure will be justified.

<sup>37</sup> Vermont State Anne Title 12 1909 (d).

<sup>38</sup> *F v R* (1983) 33 SASR.

<sup>39</sup> *F v R* (1983) 33 SASR at 193.

<sup>40</sup> Ibid

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In the Australian case of *Battersby v Tottman and State of South Australia*<sup>41</sup>, the patient was acutely depressed and dangerously suicidal. She faced the prospect of spending the remainder of her life in a mental institution. The medical practitioner decided to prescribe the drug called Melleril in large dosages to alleviate the patient mental condition. Dr Tottman was aware of the fact that one of the risks involved in such high dosages would be the danger of serious damage to the retina. It was medical knowledge that any treatment that causes impairment to the eyesight should result in the doctor ceasing such treatment. However in this case, the impairment to the patient eyesight became progressively worse even after cessation of the treatment.

The court found that the patient was likely to react hysterically and irrationally and refuse treatment not on rational grounds as a result of her distorted mental processes produced by her mental illness. The doctor believed on reasonable grounds that refusal of treatment by the patient was likely to be indeterminate close confinement in a mental institution thus causing a high risk of suicide<sup>42</sup>. Therefore the majority judgment found that the doctors decision not to disclose the risk of impairment to the patients vision was not to be found negligent.

This case is pivotal in that it provides that if an existing condition such as a mental illness causes a patient to behave neurotic and irrational upon disclosure, then non-disclosure would be justified.

#### 4.3.2 Legislation

The Access to Medical Record Act<sup>43</sup> holds that personal information regarding a patient can be withheld in limited circumstances if such disclosure might seriously harm or be detrimental to the patient physical or mental health

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#### 4.4 Canada

<sup>41</sup> *Battersby v Tottman and State of South Australia* (1985) 37 SASR 524 (South Australia Dup CT).

<sup>42</sup> *Battersby v Tottman and State of South Australia* (1985) 37 SASR 524 (South Australia Dup CT) at 527.

<sup>43</sup> Access to Medical Record Act CGS 20-7c(d)



#### 4.4.1 ~~and its~~ Common Law

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In *Rodgers v Whitaker*<sup>44</sup>, Mrs Whitaker had been almost blind in her right eye. She consulted Dr Rodgers an ophthalmic surgeon who advised her that an operation would restore sight to the eye. There was no improvement and she developed an inflammation in the left eye, which led to loss of sight in the left eye. She sued Dr Rodgers for negligence in failing to inform her that she might develop sympathetic ophthalmia in the left eye as a result of surgery.

The court recognized therapeutic privilege as a defence to informed consent which may justify withholding information that would harm the patient health, but found that the circumstances of this case did not give rise to a basis for invoking this exception as a defence<sup>45</sup>.

*Reibl v Hughes*<sup>46</sup>, during or immediately after surgery Reibl suffered a massive stroke causing paralysis on the right side of his body and impotency. Stroke, paralysis and even death were among the risks associated with his surgery. When Reibl enquired about the possibility of a stroke, the surgeon did not inform him of his chance of being paralyzed during or after the operation, but instead stressed the chances of paralysis if the patient did not undergo the surgery. The plaintiff testified that had he known of such risks he would have foregone the operation and live a shorter normal life rather than a crippled one.

The court recognized the right of the medical practitioner to withhold information from the patient under certain circumstances. Such circumstances include where the patient may because of emotional factors be unable to cope with facts necessary for recommended treatment or operation. In such cases the medical practitioner is justified in withhold or generalizing the information opposed to which he would otherwise be required to be more specific<sup>47</sup>.

<sup>44</sup> *Rodgers v Whitaker* (1992) 175 CLR 479.

<sup>45</sup> *Rodgers v Whitaker* (1992) 175 CLR 479. ~~Ibid~~

<sup>46</sup> *Reibl v Hughes* (1981) 114 DLR (3d) 1.

<sup>47</sup> *Reibl v Hughes* (1981) 114 DLR (3d) 1 at 13.

In the case of *Videto v Kennedy*<sup>48</sup>, Justice Grange in the court a quo alluded to a possible discretion to disclosure and stated that under certain circumstances it may be regarded as a disservice to warn a patient<sup>49</sup>. In an appeal, the Ontario Court of Appeal<sup>50</sup> recognized a physician's privilege to withhold certain information by following the finding of *Reibl v Hughes*. It subsequently reached the conclusion that the emotional condition of the patient, the patient's apprehension and reluctance to undergo the operation may in certain cases justify the surgeon in withholding or generalizing information as to which he would otherwise be required to be more specific<sup>51</sup>.

From the above two cases of *Reibl* and *Videto* it is evident that therapeutic privilege will be justified in cases whereby the emotional condition of the patient renders the patient unstable and unable to bear the facts and make a rational decision.

#### 4.4.2 Legislation

The Ontario Personal Health Information Protection Act<sup>52</sup> regulates the manner in which personal information may be disclosed in the health care system. Such information will not be disclosed if it will be prejudicial to the patient's health and well-being.

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#### 4.4.3 Academic Writers

According to a Canadian academic writer Dr Claude Richard, a process justifying the use of therapeutic privilege was essential. Dr Richard together with other writers formulated a 6 step therapeutic reflexive process to determine if the physician has acted responsibly when withholding or transmitting altered information to the patient.

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Step 1- the physician must be sure that the information shared with the patient hides known facts. If after careful consideration the answer to the first question is 'yes', then the

<sup>48</sup> *Videto v Kennedy* (1980) 107 DLR (3d) 612 (Ontario High Court).

<sup>49</sup> *Videto v Kennedy* (1980) 107 DLR (3d) 612 (Ontario High Court) at 622.

<sup>50</sup> *Videto v Kennedy* (1981) 17 CCLT 307 (Ontario Court of Appeal).

<sup>51</sup> *Videto v Kennedy* (1981) 17 CCLT 307 (Ontario Court of Appeal) at 133.

<sup>52</sup> Ontario Personal Health Information Protection Act 2004 S.O. C3

physician must examine the reasons why he/she chose to hide the facts. Such reasons must be reasonable and justifiable<sup>53</sup>.

Step 2- is the decision not to present the facts likely to increase the patient's well-being significantly or prevent a significant suffering? The use of therapeutic privilege can be considered only if it is for the patient's good and benefit. Expecting a foreseeable reaction of despair or anger from the patient which would make the physician embarrassed or uncomfortable can never justify the use of the defence of therapeutic privilege. In such circumstances the physician would be acting out of personal interest<sup>54</sup>.

Step 3- Does the benefit of withholding information surpass the detrimental consequences of denying a patient their right to know the truth? If the patient discovers the truth they may face loss of trust in the health care system, precipitation of emotional distress or shock, anger at having being betrayed and disappointment. Not only must the physician have good reasons for his course of action, but he/she must be confident that there is a reasonable likelihood that the patient will believe him/her. If what the physician says is not credible, he/she can expect it to have a negative impact on the patient, such as the loss of trust and this is more likely to result in the loss of harm. Therefore the physician must be sure that the benefits of withholding information outweighs the disadvantage of making a full disclosure<sup>55</sup>.

Step 4- is there any other possible course of action that would have a greater respect for the patient's right to know? In other words the physician must be sure that there is no other way to proceed that would show greater respect for the patient's right to be informed and would avoid potentially negative consequences for the patient<sup>56</sup>.

Step 5- Does the physician know what the patient's point of view is about the importance

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<sup>53</sup> C Richard 'Therapeutic Privilege: Between the Ethics of Lying and the Practice of Truth' (2010) 36 *Journal of Medical Ethics* 353, 356.

<sup>54</sup> Richard (note 44 above) 356-357.

<sup>55</sup> C Richard 'Therapeutic Privilege: Between the Ethics of Lying and the Practice of Truth' (2010) 36 *Journal of Medical Ethics* 353, 357.

<sup>56</sup> Ibid ; see chapter 5 below.

of the information hidden? The evaluation of importance of information differs depending on who the physician or patient is. However, if the physician believes that he/she understands the patient's point of view after talking to the patient then the legitimacy of the decision is approved. Similarly resorting to a member of the family who can tell the physician about the patient's character and probable reactions can also legitimate withholding information. This is only possible if the physician has the patient's permission to discuss health care matters with specific third parties<sup>57</sup>.

Step 6- A simple test would be to ask the physician if he/she is prepared to defend his defence of therapeutic privilege publically before the court in the event of a complaint? The physician must be confident about his decision to withhold information in that it is based on legitimate arguments<sup>58</sup>.

#### **4.5 CONCLUSION**

It is the medical practitioner who decides whether he/she should disclose necessary information to the patient enabling them to make rational decision regarding the intervention. This decision is based primarily on the 'patient's best interest'.

##### **4.5.1 Precise circumstances in which it will be in the patient's best interests to withhold information**

As evidence from common law countries, therapeutic privilege will be in the patient's best interest where:

- (a) Full disclosure poses a serious threat of physical<sup>59</sup> or psychological<sup>60</sup> detriment to the patient.

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<sup>57</sup> C Richard 'Therapeutic Privilege: Between the Ethics of Lying and the Practice of Truth' (2010) 36 *Journal of Medical Ethics* 353, 357-358.

<sup>58</sup> Richard (note 48 above) 358.

<sup>59</sup> *F v R* (1983) 33 SASR; National Health Services Act 1997; Access to Medical Records Act CGS 20-7c(d)

<sup>60</sup> *Sidaway v Board of Governors of Bethelhem Royal Hospital and the Maudsley Hospital* [1985] All ER 643 (HL) ; *Canterbury v Spence* 464 F2d 772 (1972) (DC Cir) ; *Confeldt v Tongen* 262 N.W 2d 684 (Minn 1977) ; *F v R* (1983) 33 SASR; National Health Services Act 1997; Access to Medical Records Act 20-7c(d)

- (b) Full disclosure causes the patient to become so ill and emotionally distraught making them unable to cope with the facts to such a degree leaving them unable to make a rational decision<sup>61</sup>, or their decision will complicate or hinder treatment/intervention<sup>62</sup>.
- (c) Full disclosure causes anxiety, fear, apprehension<sup>63</sup> and distress<sup>64</sup> which might affect the outcome of the medical intervention, thus having a detrimental effect on the patient's health<sup>65</sup>.
- (d) Full disclosure would seriously upset the patient rendering them incapable of dispassionately weighing the risks of refusing to undergo the treatment or intervention<sup>66</sup>.
- (e) Full disclosure would unduly agitate or undermine an unstable patient<sup>67</sup>.
- (f) Full disclosure endangers the recovery of a patient because of an existing mental or physical condition<sup>68</sup>. In the case of a mentally ill patient, full disclosure may cause the patient to act hysterically eg become suicidal or irrationally refuse treatment on irrationally grounds jeopardizing recovery<sup>69</sup>. Such disclosure would be insensitive and inhumane.
- (g) Full disclosure could reasonably be expected to adversely and substantially affect the patient's condition<sup>70</sup>.
- (h) The patient's temperament is such that he/she will be unable to make a rational

<sup>61</sup> *Canterbury v Spence* 464 F2d 772 (1972) (DC Cir).

<sup>62</sup> *Canterbury v Spence* 464 F2d 772 (1972) (DC Cir); *Cornfeldt v Tongen* 262 N.W 2d 684 (Minn 1977).

<sup>63</sup> *Roberts v Wood* 206 F Supp 579 (D Ala 1962); *Videto v Kennedy* (1980) 107 DLR (3d) 612 (Ontario High Court).

<sup>64</sup> *Cornfeldt v Tongen* 262 N.W 2d 684 (Minn 1977); National Health Services Act 1997

<sup>65</sup> Ontario Personal Health Information Protection Act 2004 S.O C3

<sup>66</sup> *Cobbs v Grant* 104 Cal Rptr 505 (1972).

<sup>67</sup> *Wilkinson v Vesey* A 2d 676 (R1 1972).

<sup>68</sup> *Tatro v Leuken Kan* 512 P2d (Kan 1973).

<sup>69</sup> *Battersby v Tottman and State of South Australia* (1985) 37 SASR 524 (South Australia Dup CT).

<sup>70</sup> New York Public Health Law 2508-d(4)(d); Vermont State Anne Title 12 1909 (d); National Health Services Act 1997; Ontario Personal Health Information Protection Act 2004 S.O C3

decision based on the full disclosure made to him/her<sup>71</sup>.

- (i) Emotional factors and condition of the patient renders him/her unstable and unable to bear the facts and make a rational decision<sup>72</sup>.
- (j) Full disclosure of remote risks might detrimentally alarm a patient. In other words where the harm caused by full disclosure exceeds the dangers of the intervention then non-disclosure seems reasonable<sup>73</sup>.

The privilege must only be invoked in the above exceptional instances and courts reject the paternalistic notion that the physician may resort to therapeutic privilege because he/she believes that disclosure may cause the patient to forego treatment which the physician feels is absolutely necessary for the patient<sup>74</sup>.

#### 4.5.2 Requirements to be met by the physician in order to justify the defence and escape liability

If the physician decides to withhold information, the burden of proof of non-disclosure lies with the physician to justify the defence<sup>75</sup>. He/she must satisfy the following requirements to escape liability for non-disclosure:

- (a) Show that his/her non-disclosure was based on one of the best interest circumstances as mentioned above.
- (b) Prove his/her defence of therapeutic privilege is justified by presenting the clinical assessment (medical evidence)<sup>76</sup> conducted based on the patients circumstances as suggested by the South African Academic writer Patrick van den Heever and by the cases of comparative law. In essence the physician must show their decision to

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<sup>71</sup> *F v R* (1983) 33 SASR.

<sup>72</sup> *Reibl v Hughes* (1981) 114 DLR (3d) 1 ; *Videto v Kennedy* (1981) 17 CCLT 307 (Ontario Court of Appeal).

<sup>73</sup> *Wasem v Laskowski* 274 NW 2d 219 (ND 1979).

<sup>74</sup> *Canterbury v Spence* 464 F2d 772 (1972) (DC Cir) at 788-789.

<sup>75</sup> *Harnish v Childrens Hospital Medical Centre* Mass 439 N.E 2d 245 (Mass 1982).

<sup>76</sup> *Sidaway v Board of Governors of Bethelhem Royal Hospital and the Maudsley Hospital* [1985] All ER 643 (HL) ;

withhold information was based on sound medical judgment<sup>77</sup> and it was not medically feasible<sup>78</sup> to make such disclosure.

- (c) Lastly the physician must also satisfy the 6 step process to justify as suggested by the Canadian academic writer Dr Claude Richard<sup>79</sup>.

If the best interest standards are met and the physician has satisfied his/her requirements, the defence of therapeutic privilege should be legally justified and the physician can escape liability for non-disclosure. The above mentioned precise best interest standards and non-liability requirements must be referred to for guidance or incorporated into South African legislation and develop the common law similar to that of the common law countries, only then will the role and parameters of therapeutic privilege become clear in future and not remain uncertain as it stands now. Furthermore it will become easier to decide if the defence is legally justified and impose liability if it is not legally justified.

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<sup>77</sup> *Canterbury v Spence* 464 F2d 772 (1972) (DC Cir).

<sup>78</sup> Texas Health and Safety Code Title 71 Art 4590 i 6.07 (a)(2).

<sup>79</sup> C Richard 'Therapeutic Privilege: Between the Ethics of Lying and the Practice of Truth' (2010) 36 *Journal of Medical Ethics* 353, 356-358.

## **CHAPTER 5**

### **CRITICAL EVALUATION OF THERAPEUTIC PRIVILEGE**

Despite the recognition of therapeutic privilege in South African law, the position as regards the defence is still very much underdeveloped. As we have seen in the previous chapter, invaluable insights could be gleaned from looking at the position in other jurisdictions, but also by looking at arguments based on the defence springing from a variety of disciplines. Since the aim of the dissertation is to define the contours of the defence, a discussion of such arguments will be essential in further defining the contours of therapeutic privilege. Therefore in this chapter, ethical and legal arguments for and against the privilege will be presented, while a legal view will be summarized and integrated in an attempt to make the boundaries of the defence more certain and clear.

#### **5. ARGUMENTS FOR AND AGAINST THERAPEUTIC PRIVILEGE**

The following arguments against therapeutic privilege, as well as counter arguments in favor of the defence will be discussed, namely: (a) therapeutic privilege undermines the patient's right to autonomy and self-determination (b) the privilege undermines the trust placed in doctors (c) therapeutic privilege is open to abuse (d) therapeutic privilege may be an easy defence to shield negligence (e) the privilege may be used to legitimize the doctor's reluctance to disclose unpleasant information (f) the ~~lp~~ack of professional expertise in predicting the effect of disclosure to the patients (g) therapeutic privilege rests on false medical assumptions that truth-telling results in non-compliance or refusal of necessary treatment (h) non-disclosure of a condition may lead to unnecessary treatment being administered and cost incurred.

##### **5.1 Therapeutic privilege undermines the patients rights to and self-determination and autonomy**

###### **5.1.1 Ethical Arguments**

The most fundamental argument amongst ethicist against therapeutic privilege is that the



defence is paternalistic and the patient's right to autonomy and self determination is seriously undermined, which is the cornerstone of the informed consent doctrine<sup>1</sup>. Coetzee argues that beneficence would logically endorse the withholding of information or telling of lies in order to induce a false sense of well-being for the patient. The better the lie the greater the assurance of good health, absence of risks and unwanted consequences. However there is no guarantee that a lie promising good health will not be discovered causing greater harm<sup>2</sup>. Ethicists argue that even when treatment options are limited, prognosis is grave and the doctor knows that such information will have a detrimental effect on the patient, however the patient has a right to know what to expect which allows the patient to prepare for what lies ahead instead of being overtaken by unexpected events<sup>3</sup>.

However Meyer<sup>4</sup> advocates in favor of the defence, in that information imparted to a patient about his illness should be planned with the same care and executed with the same skill that are demanded by any potentially therapeutic measure. He states that the amount of information given must be consonant with the needs of the recipient and the type of information must be chosen with the view of avoiding untoward reactions<sup>5</sup>.

### 5.1.2 Legal Arguments

Often lawyers are against therapeutic privilege and view it as a threat to the principle of self-determination endorsed by our law. They argue that by giving the doctor the discretion to decide whether or not to disclose information based on the best medical interests of the patient opens the back door to paternalism<sup>6</sup>. By denying the patient the rights to relevant information because the doctor fears that such information will be

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<sup>1</sup> P van den Heever 'Patients's Right to Know: Informed Consent in South African Medical Law' 1995 *De Rebus* 53, 56 ; D Welz *The Parameters of Medical Therapeutic Privilege* (unpublished LLM thesis, University of South Africa, 1998) 9 ; LC Coetzee 'A Critical Evaluation of the Therapeutic Privilege in Medical Law: Some Comparative Perspectives' (2003) 36 *CILSA* 268, 269.

<sup>2</sup> LC Coetzee 'A Critical Evaluation of the Therapeutic in Medical Law: Some Comparative Perspectives' (2003) 36 *CILSA* 268, 27 ; Lodewicus Charles Coetzee *Medical Therapeutic Privilege* (unpublished LLM thesis, University of South Africa, 2001) 39.

<sup>3</sup> AK Edwin 'Dont Lie Tell the Whole Truth: The Therapeutic Privilege- Is It Ever Justified?' (2008) 42 *GMJ* 156 ,158.

<sup>4</sup> B Meyer 'Truth and the Physician' in TL Beauchamp & S Perlin *Ethical Issues in Death and Dying* (1978) 160.

<sup>5</sup> Ibid

<sup>6</sup> D Giesen *International Medical Malpractice Law: A Comparative Study of Civil Responsibility Arising from Medical Care* (1988) 386.

detrimental to the patient's health, the doctor disregards the aspect of patient autonomy and self-determination<sup>7</sup>. Where the information withheld pertains to risks attached to the treatment or intervention, the patient is left with an unrealistically rosy picture and his/her decision to undergo the intervention based on unbalanced information cannot be said to be informed consent<sup>8</sup>. Furthermore where no further intervention is advised but an unfavorable diagnosis or prognosis is withheld, the patient is denied the opportunity of coming to terms with inescapable reality, deciding and arranging their affairs accordingly<sup>9</sup>.

The argument illustrated here is in favor of the defence of therapeutic privilege. Sometimes disclosure of diagnosis or a suspicion of a diagnosis is necessary to convince the patient to undergo the treatment, the proposed intervention or to have their health monitored which will be in their best medical interests<sup>10</sup>. This was sufficiently demonstrated in the American case of *Makino v The Red Cross Hospital case*<sup>11</sup>. The patient was told that her cholecysts is swollen by a gallbladder and she had to be hospitalized to undergo tests that would lead to a final diagnosis. Makino decided not to return to hospital not knowing the seriousness of her condition As a result her health worsened and she died 6 months later. Makino's family brought an action claiming that timely disclosure of cancer would have impelled the deceased to seek immediate medical treatment that could have saved her life. The doctor did not disclose such suspicion to the patient, hence the patient did not understand the importance of being hospitalized. The court however acknowledged the psychological blow the patient would have sustained upon being told about the suspicion of cancer and therefore the non-disclosure was justified by the medical practice of therapeutic privilege and the fact that the doctor had

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<sup>7</sup> EG Patterson 'Therapeutic Justification for Withholding Medical Information: What You Don't Know Can't Hurt You, or Can It?' (1985) 64 *Nebraska Law Review* 721, 722-723.

<sup>8</sup> LC Coetzee 'A Critical Evaluation of Therapeutic Privilege in Medical Law: Some Comparative Perspectives' (2003) 36 *CILSA* 268, 273 ; Lodewicus Charles Coetzee *Medical Therapeutic Privilege* (unpublished LLM thesis, University of South Africa, 2001) 44.

<sup>9</sup> B Meyer 'Truth and the Physician' in TL Beauchamp & S Perlin *Ethical Issues in Death and Dying* (1978) 158-159 ; *Esterhuizen v Administrator, Transvaal* 1957 3 SA 710 (T) 717 ; D Welz *The Parameters of Medical Therapeutic Privilege* (unpublished LLM thesis, University of South Africa, 1998) 9.

<sup>10</sup> LC Coetzee 'A Critical Evaluation of the Therapeutic in Medical Law: Some Comparative Perspectives' (2003) 36 *CILSA* 268, 274 ; Lodewicus Charles Coetzee *Medical Therapeutic Privilege* (unpublished LLM thesis, University of South Africa, 2001) 44.

<sup>11</sup> *Makino v The Red Cross Hospital* 1325 HANJ 103.

warned the patient twice of the necessity to be hospitalized. The court held that the doctor did not breach his duty to inform. The judge held that a doctor had a duty to explain to the patient his/her illness 'accurately and concretely', the doctor may decide when, what, how much and to whom to explain because such disclosure can affect the recovery of the patient<sup>12</sup>.

In the American case of *Canterbury v Spence*<sup>13</sup>, the court held that therapeutic privilege is recognized but it must be carefully circumscribed otherwise it might devour the disclosure rule itself.

It is submitted that the ethical argument against therapeutic privilege has no merit, because full disclosure cannot be made in every instance irrespective of the adverse consequences on the patient's health. Disclosure depends on the individual circumstances. Even though the doctor has an obligation to inform them and allow them to prepare for the future, at the same time they must act in the patient's best interest and such disclosure cannot cause more harm to the patient than that which already exist. Furthermore it is submitted that the argument provided by Meyer and the judgment in the Makino case in favor of therapeutic privilege has merit, as it provides that information disclosed should be chosen carefully by the doctor according to the needs of the patient, avoiding adverse reactions and devouring the disclosure rule completely, whilst still attempting to respect the patient's decision making capacity

## **5.2 The privilege undermines the trust placed in doctors**

### **5.2.1 Ethical arguments**

The ethical argument against therapeutic privilege is that withholding information or lying to the patient has the ability to undermine their trust placed in doctors and this occurs if the patient at some latter stage discovers the truth that they have been deceived or relevant information has been withheld from them<sup>14</sup>. The patient usually discovers the

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<sup>12</sup> *Makino v The Red Cross Hospital* 1325 HANJI 103.

<sup>13</sup> *Canterbury v Spence* 464 F2d 772 (1972) 789.

<sup>14</sup> GP Fletcher 'Medical Diagnosis: Our Right to Know the Truth' in TL Beauchamp & S Perlin *Ethical Issues in Death*

truth when he/she seeks a second opinion, through the materialization of an undisclosed risk, experiencing an undisclosed discomfort, the lack of experiencing a benefit promised by the doctor or knowledge of death approaching in the case of a terminal illness<sup>15</sup>. In such cases of truth discovery the patient is most likely to lose faith in the doctor who treated and deceived him/her and perhaps even lose faith in the medical profession as a whole<sup>16</sup>. Not only can the patient lose faith but he/she can also sue the doctor for failing to obtain informed consent.

Another downfall is that once the patient has been deceived by non-disclosure and in the absence of a second opinion, it becomes more difficult to break the bad news to them even when the time is appropriate<sup>17</sup>. This is due to the fact that if the patient discovers the truth, it may cause them to suffer emotional and psychological distress from learning about the deception induced by the doctor, in addition to the anxiety experienced upon disclosure of the actual truth which comes with knowledge of risks or diagnosis causing the patient to lose trust and feel betrayed<sup>18</sup>. For this reason the course of non-disclosure may in many instances prove to be a course from which it is difficult to divert from<sup>19</sup>. The doctors therefore feel the need to pursue the deception to avoid such reactions by the patient, despite realizing that it is time for the patient's need to be informed and they may also feel obliged to continue devising ways and methods of maintaining such deception<sup>20</sup>. If deception continues the patient can sue the doctor for failing to get informed consent.

The negative impact of deceiving or withholding information do not only affect the individual patient, but also extends and affects the entire community including the

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*and Dying* (1978) 150.

<sup>15</sup> LC Coetzee 'A Critical Evaluation of the Therapeutic in Medical Law: Some Comparative Perspectives' (2003) 36 *CILSA* 268, 276 ; Lodewicus Charles Coetzee *Medical Therapeutic Privilege* (unpublished LLM thesis, University of South Africa, 2001) 53.

<sup>16</sup> I Kennedy 'The unmasking of medicine' (1983) 9 *Journal of medical Ethics* 51, 104.

<sup>17</sup> M Gillian 'The Right to Know: The Nurses Role in Informing the Patient' (1994) 90 *Nursing Times* 46, 47.

<sup>18</sup> D Evans 'An Ethical Dilemma: The Dishonest Doctor' (1995) 30 *Nursing Forum* 5, 6.

<sup>19</sup> Lodewicus Charles Coetzee *Medical Therapeutic Privilege* (unpublished LLM thesis, University of South Africa, 2001) 54.

<sup>20</sup> Lodewicus Charles Coetzee *Medical Therapeutic Privilege* (unpublished LLM thesis, University of South Africa, 2001) 54 ; LC Coetzee 'A Critical Evaluation of Therapeutic Privilege in Medical Law: Some Comparative Perspectives' (2003) 36 *CILSA* 268, 277.

patients family<sup>21</sup>. The patient's relatives get involved when they are called aside and informed about the patient's condition. They may then assist the doctor in attempting to deceive the patient. Should the relative later become patients, they have an idea of how the process operates. This has a disadvantage for the doctors as it weakens his/her ability to reassure the patient of their condition as they are aware of the deception route that doctors commonly endure<sup>22</sup>. Therefore Myerscough<sup>23</sup> explains that unwillingness to acknowledge the truth especially in cases of terminal illness is most crucial regarding the doctor-patient relationship in that it jeopardizes confidence and trusts.

On the contrary, striving to tell the patient the whole truth in a single encounter in order to comply with the law deviates from the spirit of autonomy, because it is ignorant of the assessment of the patient's level of literacy, mental capacity or emotional state which may render them unable to make a rational decision<sup>24</sup>. If the objective is for the patient to understand the situation, then disclosure should be limited to what the patient is able to understand and remember<sup>25</sup>. In this way the trust relationship is still maintained and the ethical principles of beneficence and non-maleficence are upheld<sup>26</sup>.

### 5.2.2 Legal Arguments

One of the main reasons that legal arguments are against therapeutic privilege is based on the fact that the doctor-patient relationship is a fiduciary relationship. The fiduciary is the one who owes to another the duties of good faith, trust and confidence<sup>27</sup>. As a result patients trust their doctors to provide them with information on which they can base a decision about whether or not to proceed with the procedure or treatment<sup>28</sup>. The patient who is protected from knowing certain information is deprived of the opportunity to react

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<sup>21</sup> Ibid

<sup>22</sup> Lodewicus Charles Coetzee *Medical Therapeutic Privilege* (unpublished LLM thesis, University of South Africa, 2001) 54 ; LC Coetzee 'A Critical Evaluation of Therapeutic Privilege in Medical Law: Some Comparative Perspectives' (2003) 36 *CILSA* 268, 277.

<sup>23</sup> PR Myerscough *Talking with the Patient: A Basic Clinical Skill* (1989) 60-61.

<sup>24</sup> C Richard 'Therapeutic Privilege: Between the Ethics of Lying and the Practice of Truth' (2012) 36 *Journal of Medical Ethics* 353, 359.

<sup>25</sup> Ibid

<sup>26</sup> Richard (note 24 above) 359.

<sup>27</sup> AK Edwin 'Don't Lie but Don't Tell the Whole Truth: Therapeutic Privilege-Is It Ever Justified?' (2008) 42 *GMJ* 156, 159.

<sup>28</sup> Ibid

to the information in an appropriate way or he/she may even evoke a state of affairs in their imagination that is much worse than the undisclosed reality<sup>29</sup>. Trust cannot be built on untruthfulness, therefore it is important that doctors truthfully disclose information to their patients<sup>30</sup>. This will foster and maintain trust in the doctor-patient relationship as well as help patients to understand and deal with difficult situations that they maybe facing.

Further illustrating the negative effect of therapeutic privilege on the doctor patient relationship is found in the case of *Goorkani v Tayside Health Board*<sup>31</sup> in which the patient lost sight in his right eye. He then experienced inflammation in his left eye. The doctor decided to treat the patient with Chlorambucil. This drug was effective and saved sight in the left eye, however it caused the patient to be reversibly infertile. Being aware of such a risk, the doctor never informed the patient accordingly<sup>32</sup>. Lord Cameron held that the doctor had been negligent in failing to inform the patient of the risk of infertility<sup>33</sup>. The court thought it was reasonable to assume that if the patient discussed the risk of infertility with his wife and had given informed consent, there would have been less tension in the marriage<sup>34</sup>. The court assessed the amount of compensation by taking into account the loss of self esteem, anxiety, distress, shock and anger at the discovery of his infertility together with frustration and disruption experienced in his marital relationship<sup>35</sup>.

In order to prove therapeutic privilege is not justified, a study was conducted by Phatouros and Blake<sup>36</sup> to test whether full disclosure causes more anxiety. Two sheets with differing information (some had general information others had details information)

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<sup>29</sup> EG Patterson 'Therapeutic Justification for Withholding Medical Information: What You Don't Know Can't Hurt You or Can It?' (1985) 64 *Nebraska Law Review* 721, 744-745.

<sup>30</sup> AK Edwin 'Don't Lie but Don't Tell the Whole Truth: Therapeutic Privilege-Is It Ever Justified?' (2008) 42 *GMJ* 156, 159.

<sup>31</sup> *Goorkani v Tayside Health Board* 1991 SLT 94.

<sup>32</sup> *Goorkani v Tayside Health Board* 1991 SLT 94 at 95L.

<sup>33</sup> *Goorkani v Tayside Health Board* 1991 SLT 94 at 95L.

<sup>34</sup> *Goorkani v Tayside Health Board* 1991 SLT 94 at 96E.

<sup>35</sup> *Goorkani v Tayside Health Board* 1991 SLT 94 at 96F.

<sup>36</sup> CC Phatouros & MP Blake 'How Much Now to Tell? Patient Attitudes to an Information Sheet Prior to Angiography and Angioplasty' (1995) 39 *Australasian Radiology* 135, 135.

were allocated to different groups of patients who were undergoing invasive radiological procedure. The patients responses to the information were recorded. According to Phatouros and Blake there were no differences between the two groups in with respect to the anxiety caused by the highly detailed risk disclosure<sup>37</sup>. This is strong evidence that disclosure of complications associated with the medical interventions or diagnosis does not raise the patient's level of anxiety, therefore there is no need to resort to therapeutic privilege as there will be no harm incurred by the patient by full disclosure.<sup>38</sup>

An argument in favor of the defence is that disclosure of the whole truth particularly the risks should not be disclosed as it might cause the patient to become distressed and may even worsen his/her medical condition<sup>39</sup>. Not only does this assume that the patient will respond by being distressed, but that such distress will be sufficiently great to minimize his/her right to make a rational decision<sup>40</sup>. Furthermore based on the fiduciary relationship, many patients do not have the time to seek a second opinion therefore they rely and trust the information provided by their physician as being true<sup>41</sup>. Thus it is important for the physician to provide information which will be in the best interest of the patient, putting aside his/she self-interest<sup>42</sup>.

At first instance it is useful for the doctor to inform the patient in a sensitive or appropriate manner to prevent the patient from discovering that information was withheld, which would cause more harm to their well-being<sup>43</sup>. The crucial factor in disclosing potentially disturbing information is how the disclosure is made to the patient<sup>44</sup>. Failing to ensure the patient understands and grasps the basic nature of the procedure or treatment undermines informed consent<sup>45</sup>. The physician's sensitive communication has shown to ease anxiety and improve health outcomes<sup>46</sup>. Increased levels of communication and

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<sup>37</sup> Ibid

<sup>38</sup> LC Coetzee 'A Critical Evaluation of Therapeutic Privilege in Medical Law: Some Comparative Perspectives' (2003) 36 *CILSA* 268, 286-287.

<sup>39</sup> S McClean & G Maher *Medicine Moral and the Law* (1983) 74.

<sup>40</sup> Ibid

<sup>41</sup> L Bernard 'Resolving Ethical Dilemmas: A Guide for Clinicians 4ed (2009) 32.

<sup>42</sup> Ibid

<sup>43</sup> AK Edwin 'Dont Lie Tell the Whole Truth: The Therapeutic Privilege-Is It Ever Justified?' (2008) 42 *GMJ* 156, 160.

<sup>44</sup> Ibid

<sup>45</sup> SM Chafe 'Legal Obligation of Physicians to Disclose Information to Patients' (1991) 144 *CMAJ* 683, 683.

<sup>46</sup> P Ray & MD Chair 'Withholding Information from Patients' 2006 2-A-06 *CEJA Report* available at

information sharing may also contribute to higher levels of patient satisfaction and potentially decrease malpractice liability<sup>47</sup>.

It is submitted that in light of the ethical and legal arguments presented above, it is established that the doctor patient relationship must be based on trust. It cannot be argued that the practitioner must abide by truth telling by disclosing relevant information sensitively. Patients whom are informed can share their concerns about the illness with family. In addition the informed patient can ~~identify~~ better identify with his doctor and has a more satisfactory relationship with the doctor. Lastly the informed patient not only has lose hope, but they have higher confidence in the treatment that they receive<sup>48</sup>. At the same time it is important to remember that legally there are instances in which truth telling can be qualified and the doctor will be justified in not disclosing accurately and concretely.

### **5.3 Therapeutic privilege is open to abuse**

The defence of therapeutic privilege is open to abuse<sup>49</sup>. The Commission on Ethical and Legal Implications of Informed Consent is of the opinion that there is much to suggest that therapeutic privilege has been vastly overused as an excuse for not giving patient the relevant information to which they are entitled<sup>50</sup>.

#### **5.3.1 Ethical Arguments**

The argument against the privilege is that it can also be used to manipulate patients to consent to a medical intervention for the doctors financial gain or in the interest of experimentation<sup>51</sup>. Below is a case scenario in which it documents an instance where

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<http://www.ama-assn.org/resources/docs/code-medical-ethics/8082a.pdf>, accessed on 30 August 2014

<sup>47</sup> Ibid

<sup>48</sup> Lodewicus Charles Coetzee *Medical Therapeutic Privilege* (unpublished LLM thesis, University of South Africa, 2001) 75.

<sup>49</sup> LC Coetzee 'A Critical Evaluation of Therapeutic Privilege in Medical Law: Some Comparative Perspectives' (2003) 36 *CILSA* 268, 281 ; Lodewicus Charles Coetzee *Medical Therapeutic Privilege* (unpublished LLM thesis, University of South Africa, 2001) 60.

<sup>50</sup> *Presidents Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research* 1 (1982) 96

<sup>51</sup> Ibid



non-disclosure been justified by therapeutic privilege, but in the opinion of Wyden it is a glaring abuse of the defence in the interest of experimentation. There were 28 schizophrenic patients involved in a study for 7 days in which their medication was withdrawn. The aim of the study was to determine how long it would take before the patient to relapse into schizophrenia. All the participants relapsed into schizophrenia. The consent forms did not disclose the likelihood of a relapse. When the complaints about failure to disclose such risks, the defence to non-disclosure was that talking to patients about schizophrenia might cause unnecessary anxiety<sup>52</sup>. The therapeutic privilege defence was clearly abused in this case. The non-disclosure was in the interest of experimentation and not justified by therapeutic privilege.

Even if the court were to declare the invocation of therapeutic privilege to be unjustified in the above case, it will still illustrate that doctors are able to overuse, abuse and extend the scope of the defence of therapeutic privilege with ease, thereby eroding the patient right to self-determination<sup>53</sup>. The therapeutic privilege can provide the doctor with the defence enabling them to defend and rationalize their attempt to withhold information and conceal the truth under circumstances where the non-disclosure amounts to abuse<sup>54</sup>.

On the contrary, in some research there exists the concern that full disclosure to the subjects or providing them with accurate description of certain information such as the purpose or procedure would adversely affect the data and validity of the research<sup>55</sup>. The Review Board can approve of withholding or altering information, provided it determines that complete disclosure or non-deception is more likely to be harmful in itself<sup>56</sup>. Approval is only authorized if the Review Board is completely satisfied that sufficient information will be disclosed to the subjects and they be given a fair opportunity to decide whether or not to participate in the research<sup>57</sup>.

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<sup>52</sup> PA Wyden *Conquering Schizophrenia* (1998) 184-185.

<sup>53</sup> LC Coetzee 'A Critical Evaluation of Therapeutic Privilege in Medical Law: Some Comparative Perspectives' (2003) 36 *CILSA* 268, 282 ; Lodewicus Charles Coetzee *Medical Therapeutic Privilege* (unpublished LLM thesis, University of South Africa, 2001) 62.

<sup>54</sup> Ibid

<sup>55</sup> D Baumrind 'IRB and Social Science Research: Cost of Deception' (1979) 1 *IRB Ethics and Human Research* 1, 1.

<sup>56</sup> Ibid

<sup>57</sup> Baumrind (note 55 above) 1

### 5.3.2 Legal Arguments

Similar to the ethical argument against the defence, there is always the disadvantage that therapeutic privilege allows the doctor to manipulate a patient into consenting to treatment or an intervention<sup>58</sup>. It is usually the mentally competent patient<sup>59</sup> who are most vulnerable to the manipulation by doctor and who may upon being properly informed refuse a medical intervention for reasons which the doctor regards as incorrect. Molnar<sup>60</sup> states that if medical practitioners were to inform the patient of all the complications and risks attached to an operation, no patient would ever have an operation. If the medical practitioner feels the patient needs the treatment, they will withhold such information from the patient to ensure the patient undertakes the intervention<sup>61</sup>. This is an absolute abuse of the defence of therapeutic privilege unless it was a case of emergency<sup>62</sup>.

Many doctors are in favor of the defence and revert to non-disclosure in the face of uncertainty about the patient's prognosis and course of treatment<sup>63</sup>. This is important because it is safer for the doctor to remain silent than to disclose to the patient incorrect information, which may cause unnecessary harm to the patient's health<sup>64</sup>. The doctor should be extra vigilant to ensure that patient are given correct information they need in order to participate in the decision making process. Effective disclosure ensures no abuse of the privilege<sup>65</sup>.

If the doctor acts out of improper motive, they cannot use the defence of therapeutic privilege because it is not in the best interest of the patient<sup>66</sup>. It is submitted that due to the fact that therapeutic privilege has been frequently exploited by the doctors, he/she should not be able to use it in order to escape liability.

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<sup>58</sup> RR Faden & TL Beauchamp *A History and Theory of Informed Consent* (1986) 364.

<sup>59</sup> SA Strauss *Doctor, Patient and the Law: A Selection of Practical Issues* 3ed (1991) 37-39, 4-8.

<sup>60</sup> J Molnar 'Consent in the 90's' (1997) 16 *Medicine and the Law* 567, 576.

<sup>61</sup> Ibid

<sup>62</sup> LC Coetzee 'A Critical Evaluation of Therapeutic Privilege in Medical Law: Some Comparative Perspectives' (2003) 36 *CILSA* 268, 281; Lodewicus Charles Coetzee *Medical Therapeutic Privilege* (unpublished LLM thesis, University of South Africa, 2001) 61.

<sup>63</sup> AK Edwin Dont Lie Tell the Whole Truth: The Therapeutic Privilege-Is It Ever Justified?' (2008) 42 *GMJ* 156, 160.

<sup>64</sup> Ibid

<sup>65</sup> Edwin (note 63 above) 160.

<sup>66</sup> Ibid

## 5.4 Therapeutic privilege maybe an easy defence to shield negligence

### 5.4.1 Ethical Arguments

Often family members ask the physician to withhold a terminal or serious diagnosis or prognosis from the patient<sup>67</sup>. Usually the family's motive is laudable and they want to spare their loved ones the potentially painful experience of hearing difficult facts<sup>68</sup>, but the doctors use this suggestion as an escape route for their negligence of not obtaining the patient's consent. Family pressure as a defence for resorting to therapeutic privilege should be resisted if it is not justified<sup>69</sup>. These fears are unfounded and a discussion with family members reassuring them that disclosure will be done sensitively will help allay these concerns<sup>70</sup>.

However there remains another principle that should be born in mind from a ethical point of view but is not as legal obligation in favor of the defence. The physician should in cases where it is impossible to communicate the facts to the patient, the physician should tell the near relatives or a proxy who may give consent in the best interest of the patient<sup>71</sup>. This must be done with the patients consent else it would be an invasion of the patients confidentiality and privacy<sup>72</sup>.

### 5.4.2 Legal Arguments

A common argument against therapeutic privilege is when the doctor uses the defence as a shield. This occurs when the doctor is unable to reach a timely or accurate diagnosis<sup>73</sup> of an illness or when they feel the patient will refuse consent if fully informed, the doctor

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<sup>67</sup> CH Braddock 'Truth Telling and Withholding Information' Ethics in Medicine (1998) available at <http://depts.washington.edu/biothx/topics/truth.html>, accessed on 29 August 2014.

<sup>68</sup> CH Braddock 'Truth Telling and Withholding Information' Ethics in Medicine (1998) available at <http://depts.washington.edu/biothx/topics/truth.html>, accessed on 29 August 2014.

<sup>69</sup> Ibid

<sup>70</sup> CH Braddock 'Truth telling and withholding information' Ethics in medicine 1998 available at <http://depts.washington.edu/biothx/topics/truth.html>, accessed on 29 August 2014.

<sup>71</sup> W Smith 'Therapeutic Privilege to Withhold Specific Diagnosis from the Patient Sick with Serious or Fatal Illness' (1946) 14 *Tennessee Law Review* 351, 356.

<sup>72</sup> A Margaret 'Therapeutic Privilege: Variation on the Theme of Informed Consent' (1984) 12 *Law, Medicine and Health Care* 7, 7.

<sup>73</sup> SA Strauss *Doctor, Patient and the Law: A selection of practical issues* 3 ed (1991) 21.

intentionally decides to withhold information from the patient. When such non-disclosure is challenged in a suit brought by the patient against the doctor for failing to obtain informed consent, the doctor raises the defence of therapeutic privilege<sup>74</sup>. Therefore if a broad absolute privilege were granted to a physician to withhold medical information on allegedly therapeutic grounds, this will afford an easy defence used by the medical practitioners as a shield to cover the negligence<sup>75</sup>. The physician could always say that he knew the diagnosis but withheld it for fear of worsening the patient's condition<sup>76</sup>. It is extremely dangerous to say the 'doctor knows best' and it would only make the patient more sick to hear the risk<sup>77</sup>.

At the same time there exist legal arguments in favor of the defence. Knowing there are legal consequences for negligent non-disclosure without justified reasons should make doctors more candid when it comes to withholding information from their patient's<sup>78</sup>. Although disclosing unpleasant news is never a pleasant task for any doctor, it should never be an excuse for failing to disclose and obtaining informed consent, unless such disclosure could be harmful to the patient's best interest<sup>79</sup>.

These arguments have merit in that it is true that both the ethical and legal arguments regarding therapeutic privilege is used as an easy defence to shield negligence, but it should no longer be an easy escape route, as requirements have to be met in future by the physician, one of which is stipulated in the ethics argument. Furthermore the physician will have to prove all the requirements and will not succeed by just saying that he/she knew what's best.

### **5.5 The privilege maybe used to legitimize the doctor's reluctance to disclose unpleasant information**

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<sup>74</sup> MA Earl 'Informed Consent: Is there Room for the Reasonable Patient in South African Law?' (1995) 112 *SALJ* 629, 631.

<sup>75</sup> Strauss *Doctor, Patient and the Law: A Selection of Practical Issues* 3 ed (1991) 21.

<sup>76</sup> W Smith 'Therapeutic Privilege to Withhold Specific Diagnosis from the Patient Sick with Serious or Fatal Illness' (1946) 14 *Tennessee Law Review* 351, 351.

<sup>77</sup> Ibid

<sup>78</sup> AK Edwin Dont Lie but Don't Tell the Whole Truth: The Therapeutic Privilege-Is It Ever Justified?' (2008) 42 *GMJ* 156, 161.

<sup>79</sup> Ibid

### 5.5.1 Ethical Arguments

Buckman<sup>80</sup> identifies various factors in favor of invoking the defence due to the difficulty of breaking bad news for the doctor. These include<sup>81</sup> :

(1) Doctors are generally taught to relieve pain and if it is necessary to inflict pain they usually give an anesthetic to minimize or remove pain, therefore they fear causing pain by giving bad news.

(2) Doctors are likely to experience the sympathetic pain and discomfort by being in the same room as the patient who is going through the distress and anxiety caused by the bad news, therefore doctors do not like to be the bearer of bad news

(3) Doctors fear being blamed firstly for being the messengers of bad news, because patients tend to blame the messenger for the bad news and direct their anger at the messenger. Secondly during medical training, doctors are instilled with a feeling that when a patient's health deteriorates there must be someone at fault so they believe that if they break the bad news to the patient, the patient in return will blame ~~the~~ him/her.

(4) Doctors fear being the bearer of bad news especially if they have not been taught how to do it properly without causing more harm to the patient. Therefore doctors feel uneasy to break bad news to the patient and seldomly do so.

(5) Doctors are taught not to do anything unless they know what to do if something goes wrong and how to cope with a patient's emotional reaction. Therefore doctors avoid disclosing information to the patient which they feel will be detrimental, because the information may evoke a reaction which the doctor is incapable of dealing with.

(6) Importantly doctors are taught not to express their emotions such as panic, stress, confusion and rage especially during the process of decision making. This will indicate to

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<sup>80</sup> Buckman *How to Break Bad News: A Guide for Health Care Professionals* (1992) 18-21.

<sup>81</sup> Ibid

the patient that the medical practitioner is being logical, objective and also in the interests of maintaining the trust of the patient. Doctors withhold information because they fear expressing their emotions as required by the profession not to express emotions. The ideal professional is one who never reveals his/her emotions at any time and cool, calm and brave.

(7) The fear of medical hierarchy, in that younger doctors find it difficult to respond to the patient's desire for information if it seems that they have to conflicts with a higher authority's decision not to do so.

Doctors own emotional reluctance, embarrassment, fears, and anxiety to confront the patient with stark diagnosis and risks often are the reason for non-disclosure<sup>82</sup>. Meyer<sup>83</sup> is in line with ethics and he denotes that there is an increase in doctors avoiding being the bearer of bad news to the patients.

On the contrary, the information that doctors give patients maybe related to their own level of competence and in the subsequent communication that such disclosure would necessitate rather than to the patient's ability to accept such information<sup>84</sup>. If this continues, it means that informed consent is under serious threat of being undermined by therapeutic privilege which sets a smoke screen behind which the doctor can safely take retreat for imposing their perception and beliefs on the patient's life<sup>85</sup>.

### 5.5.2 Legal Arguments

A major argument against the privilege is where motivation to withhold the truth from the patient originates from the doctors unwillingness to be the bearer of bad news<sup>86</sup>. One can

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<sup>82</sup> A Meisel & JDM Kuczewski 'Legal and Ethical Myths about Informed Consent' (1996) 156 *Archives of Internal Medicine* 2521, 2525.

<sup>83</sup> B Meyer 'Truth and the Physician' in TL Beauchamp & S Perlin *Ethical Issues in Death and Dying* (1978) 156-157.

<sup>84</sup> Lodewicus Charles Coetzee *Medical Therapeutic Privilege* (unpublished LLM thesis, University of South Africa, 2001) 65.

<sup>85</sup> Ibid

<sup>86</sup> Lodewicus Charles Coetzee *Medical Therapeutic privilege* (unpublished LLM thesis, University of South Africa, 2001) 66.

expect the temptation to withhold the truth to increase with grimness of the information<sup>87</sup>. It stands to reason that this poses a serious threat to self-determination of the patient<sup>88</sup>

However the scenario maybe reversed if the patient states an informed preference not to be told the truth<sup>89</sup>. In such cases therapeutic privilege is favored and patients might ask the physician instead to consult family members or a proxy for instance, but in these cases it is critical that the patient give thought to the implication of passing their role in decision making<sup>90</sup>. If they choose to make an informed decision not to be informed such a preference must be respected by the physician<sup>91</sup>. To respect the right of self-determination the doctor can also ask the patient to specify the scope and method of information, such preferences should be honored<sup>92</sup>.

It is submitted that doctors should not avoid disclosing information to patients based on their emotions and feelings. Instead they should query from the patient their wishes and respect such wishes if it is in the best interest of the patient.

## **5.6 The lack of professional expertise in predicting the effect of disclosure of information to patients**

### **5.6.1 Ethical Arguments**

One of the arguments against therapeutic privilege is that the medical profession lacks the expertise to predict whether the disclosure of information to a particular patient will have a positive, negative or no effect<sup>93</sup>. The existence of the high error rate in assessing indicates the absence of professional expertise. Physician's may give undue emphasis to

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<sup>87</sup> Ibid

<sup>88</sup> Coetzee (note 86 above) 66

<sup>89</sup> CH Braddock 'Truth Telling and Withholding Information' Ethics in Medicine (1998) available at <http://depts.washington.edu/biothx/topics/truth.html>, accessed on 29 August 2014.

<sup>90</sup> CH Braddock 'Truth Telling and Withholding Information' Ethics in Medicine (1998) available at <http://depts.washington.edu/biothx/topics/truth.html>, accessed on 29 August 2014.

<sup>91</sup> Ibid

<sup>92</sup> P Ray & MD Chair 'Withholding Information from Patients' 2006 *CEJA 2-A-06 Report* available at <http://www.ama-assn.org/resources/docs/code-medical-ethics/8082a.pdf>, accessed on 30 August 2014.

<sup>93</sup> LC Coetzee 'A Critical Evaluation of Therapeutic Privilege in Medical Law: Some Comparative Perspectives' (2003) 36 *CILSA* 268, 285 ; Lodewicus Charles Coetzee *Medical Therapeutic Privilege* (unpublished LLM thesis, University of South Africa, 2001) 68.

medical or psychological consequences incorporating their own high fear of death. They may overlook the needs and values dear to the patient. Predicting the psychological impact of bad news on someone when he/she does not know well is a complicated task and prone to errors<sup>94</sup>.

A moral basis for invoking and favoring the defence of therapeutic privilege is for the doctor to do what is most beneficial for the patient and to avoid inflicting harm on the patient<sup>95</sup>. If disclosure of certain information is deemed to be harmful to the patient, the doctor maybe justified in withholding such information<sup>96</sup>. Therefore doctors are in the best position to make such judgment based on their experience, skill and most importantly the clinical assessment conducted of the patient<sup>97</sup>.

#### 5.6.2 Legal Arguments

s8(3)<sup>98</sup> of the NHA favors the defence in that it allows or may compel them to postpone the full disclosure of information to the patient whose capacity to hear, accept and deal with such information maybe comprised. In other words, delay disclosure until the patient is able to handle the information or disclose partial information and later make full disclosure when the patient is better able to accept it<sup>99</sup>.

When the physician decides to delay disclosure he/she is also encouraged to consult colleagues or hospital ethics committee when considering the need to temporarily withhold information from patient<sup>100</sup>. Such consultations respect the patient's right of self-determination<sup>101</sup>. When the physician decides that a patient should not receive all the information at a given time, they need to continue to provide appropriate care and

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<sup>94</sup> Ibid

<sup>95</sup> AK Edwin Dont Lie but Don't Tell the Whole Truth: The Therapeutic Privilege-Is It Ever Justified?' (2008) 42 *GMJ* 156, 160.

<sup>96</sup> AK Edwin Dont Lie but Don't Tell the Whole Truth: The Therapeutic Privilege-Is It ever Justified?' (2008) 42 *GMJ* 156, 160.

<sup>97</sup> Ibid

<sup>98</sup> S 8(3) of the National Health Act 61 of 2003.

<sup>99</sup> P Ray & MD Chair 'Withholding Information from Patients' (2006) 2-A-06 *CEJA* Report available at <http://www.ama-assn.org/resources/docs/code-medical-ethics/8082a.pdf>, accessed on 30 August 2014.

<sup>100</sup> Ibid

<sup>101</sup> P Ray & MD Chair 'Withholding Information from the Patient' (2006) 2-A-06 *CEJA* Report available at <http://www.ama-assn.org/resources/docs/code-medical-ethics/8082a.pdf>, accessed on 30 August 2014.



monitor the patient to identify when is the right time to make full disclosure to ensure the information is not permanently withheld<sup>102</sup>.

On the converse, if the patient is never able to handle the information or accept it then full disclosure is withheld from the patient<sup>103</sup>. Furthermore if delayed disclosure is used to prevent a patient from refusing or instill hope for the future then therapeutic privilege in disguise of delayed disclosure is never legally justified<sup>104</sup>.

It is submitted that partial or full disclosure maybe delayed if it is in the best interest of the patient who is unable to cope with facts because of an illness. Such would be a reasonable step to take instead of disclosing to a patient who in return acts unreasonably and makes an irrational decision. In this way the self-determination of the patient is still respected.

## **5.7 Therapeutic privilege rest on false medical assumptions that truth telling results in non-compliance or refusal of necessary treatment**<sup>105</sup>

### **5.7.1 Ethical Arguments**

The Presidents Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research argue against the defence of therapeutic privilege. Surprisingly they found that patients refuse treatment not because too much information is given, but due to the fact that too less information is provided<sup>106</sup>. People who refuse treatment have said to had done so because the nature, purpose, risks and implications of the medical intervention have not been adequately explained to them to enable them to make a rational decision<sup>107</sup>. Therefore they refuse the treatment to be safe.

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<sup>102</sup> Ibid

<sup>103</sup> P Ray & MD Chair 'Withholding information from patients' (2006) 2-A-06 CEJA Report available at <http://www.ama-assn.org/resources/docs/code-medical-ethics/8082a.pdf>, accessed on 30 August 2014.

<sup>104</sup> P Ray & mD Chair 'Withholding Information from the Patient' (2006) 2-A-06 CEJA Report available at <http://www.ama-assn.org/resources/docs/code-medical-ethics/8082a.pdf>, accessed on 30 August 2014.

<sup>105</sup> Cf Molnar at 5.4.2 infra

<sup>106</sup> *Presidents Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research* 1 (1989) 102.

<sup>107</sup> Ibid

A counter argument in favor of the defence is that if too much information is given at once, the patient in conjunction with their medical condition may not be able to understand, acknowledge and appreciate the information which may render them incapable of making a rational decision<sup>108</sup>. Therefore if disclosure is less, but it is limited to the most truth and relevant information, then the decision is said to be rational<sup>109</sup>. Treatment will be accepted as being safe to commence and the patient is unlikely to refuse<sup>110</sup>.

### 5.7.2 Legal Arguments

Alfidi<sup>111</sup> decided to conduct a study with the intention of highlighting the negative impact of therapeutic privilege. The study was conducted amongst the doctors in United States of America concerning their reaction of obtaining an informed consent. When he began his study he expected to find that after comprehensive explanation was given to the patient, there would be a wholesale of patients refusing treatment<sup>112</sup>, however he was proved incorrect. The results of the study led him to believe that disclosure of complications resulted in only a small percent of patients refusing a procedure<sup>113</sup>. Therefore Alfidi's concern that informing the patient about possible complications will result in the refusal of a medical intervention is now outdated.

A common argument in favor of the defence is when patients prefer full disclosure whilst others prefer partial so that they can weigh up all the advantages and disadvantages before deciding whether or not to refuse the treatment/intervention<sup>114</sup>

The doctor should rather make a disclosure in a calm, simple, and direct manner as it

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<sup>108</sup> C Richard 'Therapeutic Privilege: Between Ethics of Lying and Practice of Truth' (2012) 36 *Journal of Medical Ethics* 353, 359.

<sup>109</sup> Ibid

<sup>110</sup> C Richard 'Therapeutic Privilege: Between Ethics of Lying and Practice of Truth' (2012) 36 *Journal of Medical Ethics* 353, 359.

<sup>111</sup> RJ Alfidi 'Informed consent: A Study of Patient Reaction' (1971) 2 *Journal of the American Medical Association* 1325, 1325.

<sup>112</sup> Ibid

<sup>113</sup> Alfidi (note 111 above) 1329.

<sup>114</sup> RJ Alfidi 'Informed consent: A Study of Patient Reaction' (1971) 2 *Journal of the American Medical Association* 1325, 1329.

establish a good doctor patient relationship<sup>115</sup>. It is submitted that the above statement has merit, because there is no strong basis for the fear that informing the patients will lead to patient refusing treatment or developing untoward reactions.

## **5.8 Non -Disclosure of the Medical Condition may lead to Unnecessary Treatment being Administered and Extra Cost being Incurred**

### **5.8.1 Ethical Arguments**

Therapeutic privilege is not justified in cases where cost are involved. If certain information is withheld, the patient does not know what they expected to pay for so they cannot exercise autonomy fully. In addition, the patient cannot exercise their right to autonomy if they have no choice as to their financial position, thus they do not satisfy beneficence and non-maleficence.

However therapeutic privilege remains argued in terms of cost. Even if partial disclosure is made to the patient, it enables them to exercise their right to autonomy which implies they have a right to decide whether to pay for medical treatment or an intervention in cash. Beneficence and non-maleficence comes into effect when the patient is able to afford to pay for the treatment.

### **5.8.2 Legal Arguments**

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<sup>115</sup> Lodewicus Charles Coetzee *Medical Therapeutic Privilege* (unpublished LLM thesis, University of South Africa, 2001) 72.

Withholding information has a negative effect in that it may lead to unnecessary treatment being administered. This was illustrated in the *Arato v Avedon* case<sup>116</sup>. In this case the surgeon did not disclose the life expectancy data to the patient, because he felt the patient would experience great anxiety over his condition and therefore in the doctor's opinion would be medically inappropriate to disclose such morbidity rates to the patient<sup>117</sup>. The patient's oncologists was also of the opinion that disclosure of such high mortality rates for cancer might deprive a patient of hope of any cure<sup>118</sup>. However the plaintiff argued that the doctors failed to disclose the shortcomings of chemotherapy and radiation therapy and further failed to obtain informed consent<sup>119</sup>. The patient also argued that the statistical morbidity rate of his pancreatic cancer was important for him to know in order to decide whether or not to undergo the treatment. Had he had known the truth of his life expectancy, he would not have undergone the therapy and would have chosen to live his last days with his family in peace and arranging his business affairs<sup>120</sup>. The patient asserted that he was given false hope that the therapies would cure him, and therefore failed to order his affairs in contemplation of his death, omission that led to failure of his contracting business and substantial real estate and tax losses following death<sup>121</sup>. Evident that non-disclosure causes harm to the patient, family and property.

On the other hand if the truth is withheld, the patient will often object to the decisive and costly forms of treatment since the urgency of undergoing the treatment will not be apparent, which saves the patient from overcharging of services<sup>122</sup>.

Doctors are in the best position to make diagnosis and prognosis and to suggest suitable treatment and alternatives. In a system which envisages self-determination of the patient, the values of the patient must be taken into consideration in making health care

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<sup>116</sup> *Arato v Avedon* 858 P 2d598 (Cal 1993)602.

<sup>117</sup> *Arato v Avedon* 858 P 2d598 (Cal 1993)602 at 600-601.

<sup>118</sup> *Arato v Avedon* 858 P 2d598 (Cal 1993)602 at 601.

<sup>119</sup> *Arato v Avedon* 858 P 2d598 (Cal 1993)602 at 602.

<sup>120</sup> *Arato v Avedon* 858 P 2d598 )Cal1993)602 at 602.

<sup>121</sup> *Arato v Avedon* 858 P 2d598 )Cal1993)602 at 602.

<sup>122</sup> LC Coetzee 'A Critical Evaluation of Therapeutic Privilege in Medical Law: Some Comparative Perspectives' (2003) 36 *CILSA* 268, 284 ; Lodewicus Charles Coetzee *Medical Therapeutic Privilege* (unpublished LLM thesis, University of South Africa, 2001) 67.

decisions<sup>123</sup>. It is submitted that in the interest of keeping the cost down, the values such as the non-medical needs of the patient should also be taken into account by the doctor. If otherwise, then patients may avoid or delay consulting with the doctor for fear that their non medical needs would be disregarded. This may result in deterioration of health standards and concomitant cost for society. Therefore to be as cost efficient as possible, doctors must make expert decisions and patients must evaluate decisions concerning their health.

## 5.9 CONCLUSION

In essence the physician has a duty to explain to the patient relevant medical information accurately and concretely. The doctor may decide when, what, how much and to whom to explain the information because disclosure can affect the recovery of the patient<sup>124</sup>.

### 5.9.1 Requirements to be met by the physician before resorting to therapeutic privilege

As mentioned in the previous chapter, once clinical assessment is indicative that full disclosure may have an adverse effect on the patient's health, as per the arguments the physician must consider the following before resorting to therapeutic privilege:

- (a) Delay full disclosure until the patient is able to handle the information. Alternatively the doctor may proceed with partial disclosure leaving the remainder information for a latter time when the patient is better able to accept and cope with the facts<sup>125</sup>. The amount of information that the doctor gives at a time must be consonant with the needs of the patient and the type of information must be chosen with the view to avoid unpleasant reacts<sup>126</sup>. The aim of this is to ensure that the patient is given all the necessary information to enable them to know what to expect which allows the patient to prepare for what lies ahead instead of being overtaken by unexpected

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<sup>123</sup> Ibid

<sup>124</sup> *Makino v The Red Cross Hospital* 1325 HANJII 103.

<sup>125</sup> B Meyer 'Truth and the Physician' in TL Beauchamp & S Perlin *Ethical Issues in Death and Dying* (1978) 158-159 ; *Makino v The Red Cross Hospital* 1325 HANJII 103.

<sup>126</sup> Ibid

events<sup>127</sup>.

- (b) Physicians must consult with colleagues or hospital ethics committee when considering temporarily withholding of information. They must also ensure that appropriate care and constant monitoring of the patient is done to identify when is the appropriate time to make full disclosure, so that the information is not permanently withheld<sup>128</sup>.
- (c) The doctor should disclose relevant information truthfully to the patient and avoid lying to the patient, because the patient trust that the doctor will provide him/her with accurate information on which they can make an informed decision<sup>129</sup>. This fosters trust in the doctor-patient relationship and helps the patient to better deal with difficult situations, whilst upholding beneficence and non-maleficence<sup>130</sup>.
- (d) Doctors should inform the patient about relevant medical information in a language simple to understand and in a sensitive manner<sup>131</sup>. If communication is done with skill and care it eases anxiety, improves health outcomes, increases levels of patient satisfaction and decreases malpractice liability<sup>132</sup>.
- (e) If it is impossible to disclose necessary information to the patient, the doctor may communicate it to the near relative with the consent of the patient<sup>133</sup>. The relative may — consent and make any decision for the patient, provided that such a decision must be in the best interest of the patient<sup>134</sup>.

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<sup>127</sup> P Ray & MD Chair 'Withholding Information from Patients' (2006) 2-A-06 *CEJA Report* available at <http://www.ama-assn.org/resources/docs/code-medical-ethics/8082a.pdf>, accessed on 30 August 2014 ; s8(3) of the National Health Act 61 of 2003 ; AK Edwin Don't Lie but Don't Tell the Whole Truth: The Therapeutic Privilege-Is It ever Justified?' (2008) 42 *GMJ* 156, 158.

<sup>128</sup> P Ray & MD Chair 'Withholding information from patients' 2006 *CEJA 2-A-06 Report* available at <http://www.ama-assn.org/resources/docs/code-medical-ethics/8082a.pdf>, accessed on 30 August 2014.

<sup>129</sup> AK Edwin Don't Lie but Don't Tell the Whole Truth: The Therapeutic Privilege-Is It ever Justified?' (2008) 42 *GMJ* 156, 157.

<sup>130</sup> AK Edwin 'Don't Lie but Don't Tell the Whole Truth: The Therapeutic Privilege-Is It Ever Justified?' (2008) 42 *GMJ* 156, 159.

<sup>131</sup> Edwin (note 130 above) 160.

<sup>132</sup> AK Edwin 'Dont lie tell the whole truth: the therapeutic privilege-is it ever justified?' (2008) 42 *GMJ* 156, 160

<sup>133</sup> W Smith 'Therapeutic privilege to withhold specific diagnosis from the patient sick with serious or fatal illness' (1946) 14 *Tennessee Law Review* 351, 356

<sup>134</sup> Ibid

- (f) The physician can also ask the patient to specify the scope and method of information. If the patient waives his/her right to be told and instead request that a family member or proxy consent and make a decision on their behalf, the doctor must honor such preference<sup>135</sup>.

In light of the above, the patients ethical and legal right to self-determination and autonomy are still respected, because the doctor discloses the relevant information to the patient and it is ultimately the patient who makes the decision whether to undergo treatment or not. Even though a family member or proxy appointed by the patient may make a decision, it can still be regarded as the patient's decision because it is made in the best interest of the patient.

It is submitted that if the physician after careful consideration is still of the opinion that despite the disclosure precautions considered above, it would still be prejudicial to the patient's recovery and the proxy would not make a decision in the best interests of the patient, then the doctor can resort to therapeutic privilege as a last resort as it will be in the best interest of the patient. Resorting to therapeutic privilege as a last resort is an additional requirement that the doctor has to prove in order to justify invocation of the defence and escape liability which will be discussed in chapter 6.

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<sup>135</sup> P Ray & MD Chair 'Withholding information from patients' (2006) 2-A-06 *CEJA Report* available at <http://www.ama-assn.org/resources/docs/code-medical-ethics/8082a.pdf>, accessed on 30 August 2014

## **CHAPTER 6**

### **CONCLUSION AND RECOMENDATIONS**

#### **6.1 CONCLUSION**

The fact that therapeutic privilege is only an exception to informed consent implies that such a defence should only be invoked in limited cases. Some argue that it reinvokes medical paternalism even in those exceptional circumstances. However our courts still allow doctors to use therapeutic privilege once a reasonable patient test is satisfied and the doctor believes it is in the patient's best interest. It is not evident in our law when the invocation of such defence is justified in terms of being in the best interest and what has to be done to justify such a defence..when it is in the patient's best interest. Therefore our ~~However the~~ law remains elusive in defining the parameters of the defence.

In this study, much has been said about how the contours of therapeutic privilege should be defined and various submissions have been made in this respect. They will not be repeated here in full and the following remarks will suffice.

##### **6.1.1 PROCEDURE TO BE FOLLOWED BY THE DOCTOR** **BEFORE RESORTING TO USING THERAPEUTIC PRIVILEGE**

It is submitted that the emphasis should be shifted from 'what to tell' to 'how to tell' and 'when to tell the patient'. Improving the quality of communication could go a long way in overcoming the problem of avoiding harm through disclosure. Therefore once the physician conducts a clinical assessment which illustrates that full disclosure may have adverse effects for the patient, it is recommended that the physician should only resort to therapeutic privilege after they have considered the following principles<sup>1</sup>:

- (a) The doctor should delay full disclosure to the patient or the doctor may proceed with

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<sup>1</sup> See para 5.9.1 above.



partial disclosure leaving the remaining information for a latter time when the patient is better able to accept and cope with the facts. Such information to be disclosed to the patient must be chosen carefully.

- (b) The doctor should when considering temporarily withholding information be advised to consult with colleagues or the hospital ethics committee and to ensure continuous observation of the patient so that the appropriate time when to make full disclosure is clearly identifiable.
- (c) The doctor should be truthful in his disclosure, as the patient uses this information as a foundation to make an informed decision and furthermore he/she should avoid any form of deception.
- (d) The doctor should be tactful, sensitive, compassionate and ensure communications are done with skill and care can provide an alternative to non-disclosure.
- (e) The doctor may communicate the information to a relative with the consent of the patient, if it is impossible to make disclosure to the patient. The relative any make a decision in the best interest and on behalf of the patient.
- (f) The doctor can also ask the patient to specify the scope and method of information. If the patient request a family member or proxy to consent and make a decision on their behalf, the doctor must honor such preference.

The above legal and ethical principles relating to therapeutic privilege illustrate that doctor should always strive to achieve a compromise which protects the patient's self-determination and autonomy without unduly restricting the medical judgment thereby ensuring an alliance between the practitioner and the patient achieving the best medical result and not harming the patient.

Therefore if the above measures are taken and the patient consents (or any person

consents on their behalf), it is indicative that the legal right to self-determination and the ethical right to autonomy is still respected and protected and not abandoned as soon as the physician's clinical assessment illustrates unfavorable results if disclosure is made.

If in some cases, the physician still has reason to believe that the considerations above may still have detrimental effects to the patient's recovery and any decision taken by the proxy will not be in the patient's best interests, then the physician can resort to therapeutic privilege as a last resort as it will be in the patient's best medical interest. To make a true assessment of the patient's best interest, the doctor needs to possess knowledge of the patient's non-medical needs and interests. The question to be answered is when is it in the patient's best interest? The principles set out below demonstrate the precise circumstances in which it will be in the best interest to rely on therapeutic privilege as a last resort.

### **6.1.2 PROCEDURE TO BE FOLLOWED BY THE DOCTOR AFTER DECIDING TO USE THERAPEUTIC PRIVILEGE**

#### **6.1.2.1 Precise circumstances in which it will be in the patient's best interest to withhold information**

If the doctor resorts to therapeutic privilege, they must only use it in the following cases where it will be in the patient's best interest. As evidence from common law countries, therapeutic privilege will be in the patient's best interest<sup>2</sup>:

- (a) Where full disclosure poses a serious threat of physical or psychological detriment to the patient.
- (b) Where full disclosure causes the patient to become so ill and emotionally distraught making them unable to cope with the facts to such a degree so as to foreclose a rational decision from being made, or causes the patient to complicate or hinder treatment/intervention.

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<sup>2</sup> See para 4.5.1 above.

- (c) Where full disclosure causes anxiety, fear, apprehension and distress which might affect the outcome of the medical intervention, thus having a detrimental effect on the patient's health.
- (d) Where full disclosure would seriously upset the patient rendering them incapable of dispassionately weighing the risks of refusing to undergo the treatment or intervention.
- (e) Where full disclosure would unduly agitate or undermine an unstable patient.
- (f) Where full disclosure endangers the recovery of a patient because of an existing mental or physical condition. In the case of a mentally ill patient, full disclosure may cause the patient to act hysterically eg suicidal or irrationally refuse treatment on irrationally grounds jeopardizing recovery. Such disclosure would be insensitive and inhumane.
- (g) Where full disclosure could reasonably be expected to adversely and substantially affect the patient's condition.
- (h) Where the patient's temperament is such that he/she will be unable to make a rational decision based on the full disclosure made to him/her.
- (i) Where emotional factors and condition of the patient renders them unstable and unable to bear the facts and make a rational decision.
- (j) Where full disclosure of remote risks might detrimentally alarm a patient. In other words where the harm caused by full disclosure exceeds the dangers of the intervention then non-disclosure seems reasonable.

Courts reject the paternalistic notion that the physician may resort to therapeutic privilege because he/she believes that disclosure may cause the patient to forego treatment which

the physician feels is absolutely necessary for the patient. Therefore it is submitted that the patient's emotional state and physical condition are important factors to be taken into consideration when deciding whether or not to withhold information since patients vary in their needs, resources and ability to integrate information. To avoid making therapeutic privilege an easy escape root for physicians, there are certainty requirements that have to be proved.

#### 6.1.2.2 Requirements to justify the defence and escape liability for non-disclosure to patients

It is submitted that if the physician resorts to the use of therapeutic privilege, he/she must be able to justify the defence in order to escape liability for non-disclosure. Therefore the physician has to satisfy the following requirements<sup>3</sup>:

- (a) Show that the limitation of self-determination and autonomy is reasonable and justifiable thus giving preference to beneficence, non-maleficence and justice.
- (b) Prove his/her defence of therapeutic privilege is justified by presenting the clinical assessment conducted based on the patients circumstances as suggested by the South African writer Patrick van den Heever and by the cases of comparative law. In essence the physician must show their decision to withhold information was based on (a) sound medical judgment and it was not medically feasible to make such disclosure (b) the physician should also present his notes, which includes the patient history, psychological profile (c) nature of diagnosis (d) risk associated with treatment (e) the doctor's observation of the patient (f) extent of non-disclosure (g) reasons for non-disclosure and (h) nature of harm the practitioner sought to avoid. These records will constitute prima facie proof of the medical practitioner's reasons of non-disclosure and could allow the medical practitioner to escape liability for non-disclosure.

- (c) The physician must also satisfy the 6 step process to justify as suggested by the

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<sup>3</sup> See para 4.5.2 above.

Canadian academic writer Dr Claude Richard .The physician must prove: (a)good reasons why facts were hidden (b) decision not to present facts were to increase the patients well-being or prevent significant suffering (c) benefits of withholding information outweigh the disadvantage of making full disclosure (d) no other alternative to prevent harm to the patient (e) he/she understands the patient's point of view (f) defence is based on legitimate arguments and he/she is not hesitant to defend the privilege before the court.

- (d) Show that his/her non-disclosure was based on one of the best interest circumstances as mentioned above.
- (e) Lastly the physician must prove that therapeutic privilege was used as a last resort after all other attempts of making any such disclosure to the patient.

## **6.2 RECOMMENDATIONS**

Firstly, the above mentioned procedures that have to be followed and satisfied before and after the doctor decides to invoke the defence of therapeutic privilege cannot be included as sections in the National Health Act 61 of 2003, simply because of the fact that it is too detailed and complexed. However to ensure that that the submissions made are not ignored, they can at best be made regulations to the NHA. Furthermore there should be a compilation of a separate booklet dedicated solely to therapeutic privilege, incorporating the principles and requirements submitted in the above study. If this cannot be accomplished due to time constraints, lack of support, or funds; then alternatively amendments must be made to the Professional Rule of Conduct of the Health Professions Council of South Africa to incorporate the above procedures so that such principles/requirements have persuasive value and are not completely disregarded.

If the limitation of self-determination/autonomy is consistent with the Constitution, the best interest standards are met and the physician has satisfied his/her requirements; then

the defence of therapeutic privilege should be legally justified and the physician can escape liability for non-disclosure. In other words, the above procedures must be incorporated into our South African legislation and the legislature must develop the common law. Only then will the role and parameters of therapeutic privilege become clear in future and not remain uncertain as it stands now. Furthermore it will become easier for the medical profession to decide if the defence of therapeutic privilege is legally justified and impose liability if it is not.

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